Reflection, Recollection, and Change: The Nevada State Board of Medical Examiners

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Description

During 1994-1995, the UNOHP collaborated with the University of Nevada History Department on a project funded by the Nevada State Board of Medical Examiners. Anita Watson, Ph.D. candidate in the History Department, conducted oral history interviews with former and current Board members, and researched and wrote this history of the Board of Medical Examiners. (The oral histories are published in a separate volume entitled, Reflection, Recollection, and Change: Oral Histories of the Nevada State Board of Medical Examiners.)

A statute of the Nevada legislature created the Nevada State Board of Medical Examiners in 1899. Medicine as a profession was developing into a structured and restricted field, and the examination and licensing of physicians was part of that development. Citizens were looking to government for protection from greedy and unscrupulous entities and individuals. Government was accepting increasing responsibility for the welfare of its citizens, and oversight and control of the individuals attending the health of its citizens was part of that obligation.

The Board of Medical Examiners began as a small, rather informal organization. The population of Nevada was low, and the physicians to be scrutinized and regulated were few. The doctors often knew each other, either personally or by reputation, and when there were problems, they were often solved without legal action.

As Nevada changed, affected by population growth and urban expansion in the second half of the twentieth century, the Board, too, evolved. The practice of medicine has been altered by technological advancement, medical progress, and modifications in the systems of health care delivery, and doctors have struggled to adapt to their changing circumstances. The oversight of physicians has become more complex in an increasingly critical and litigious society. Laws governing physicians and medical practice have also become more complicated.

Change has directed and defined the Board of Medical Examiners. The altered medical, economic, and social ideology, as well as the reality of a transformed and modernized nation and its inhabitants, has affected medicine in Nevada and the Board of Medical Examiners. The early history of the Board is revealed in the written record, the statutes, meeting notes, letters, and newspaper reports. The study of more recent events, however, has the advantage of an additional resource: oral histories of the men and women who have served on the Board of Medical Examiners. It is their words, reflections, and recollections that convey the texture of the history.

This work focuses on the establishment and development of the Nevada State Board of Medical Examiners, primarily covering the years 1899 to 1985. An overview of medical licensing and a brief history of medical legislation in Nevada provide context for the activity of the Board of Medical Examiners and the Nevada legislature. Material from the oral histories of the Board members is included to explain and illustrate the background to medical legislation.

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from the Nevada State Board of Medical Examiners.

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Preface to the Digital Edition

Established in 1964, the University of Nevada Oral History Program (UNOHP) explores the remembered past through rigorous oral history interviewing, creating a record for present and future researchers. The program's collection of primary source oral histories is an important body of information about significant events, people, places, and activities in twentieth and twenty-first century Nevada and the West.

The UNOHP wishes to make the information in its oral histories accessible to a broad range of patrons. To achieve this goal, its transcripts must speak with an intelligible voice. However, no type font contains symbols for physical gestures and vocal modulations which are integral parts of verbal communication. When human speech is represented in print, stripped of these signals, the result can be a morass of seemingly tangled syntax and incomplete sentences—totally verbatim transcripts sometimes verge on incoherence. Therefore, this transcript has been lightly edited.

While taking great pains not to alter meaning in any way, the editor may have removed false starts, redundancies, and the "uhs," "ahs," and other noises with which speech is often liberally sprinkled; compressed some passages which, in unaltered form, misrepresent the chronicler's meaning; and relocated some material to place information in its intended context. Laughter is represented with [laughter] at the end of a sentence in which it occurs, and ellipses are used to indicate that a statement has been interrupted or is incomplete…or that there is a pause for dramatic effect.

As with all of our oral histories, while we can vouch for the authenticity of the interviews in the UNOHP collection, we advise readers to keep in mind that these are remembered pasts, and we do not claim that the recollections are entirely free of error. We can state, however, that the transcripts accurately reflect the oral history recordings on which they were based. Accordingly, each transcript should be approached with the

same prudence that the intelligent reader exercises when consulting government records, newspaper accounts, diaries, and other sources of historical information. All statements made here constitute the remembrance or opinions of the individuals who were interviewed, and not the opinions of the UNOHP.

In order to standardize the design of all UNOHP transcripts for the online database, most have been reformatted, a process that was completed in 2012. This document may therefore differ in appearance and pagination from earlier printed versions. Rather than compile entirely new indexes for each volume, the UNOHP has made each transcript fully searchable electronically. If a previous version of this volume existed, its original index has been appended to this document for reference only. A link to the entire catalog can be found online at http://oralhistory.unr.edu/.

For more information on the UNOHP or any of its publications, please contact the University of Nevada Oral History Program at Mail Stop 0324, University of Nevada, Reno, NV, 89557-0324 or by calling 775/784-6932.

Alicia Barber
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July 2012

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Introduction and Overview of American Medicine

In the preface to his history of medical licensing in America, Richard Shryock notes that rather early after settlement, in 1649, the colony of Massachusetts created a law that would restrict those "Chirurgeons, Midwives, Physitians or others . . . imployed at any time about the bodye of men, women or children, for the preservation of life, or health." Those individuals were to seek "the advice and consent of such as are skillful in the same Art (if such may be had) or at least some of the wisest and gravest then present."[1] Two hundred and fifty years later, the legislature in the State of Nevada was seeking essentially the same ends when the State Board of Medical Examiners was created. Couched in more modern terms, the act that created the Board called for five individuals, each a "reputable practicing physician," who would be charged with the responsibility of examining and issuing certificates to physicians seeking to practice medicine and surgery in Nevada.

The statute creating the Board of Medical Examiners was passed in 1899. Its establishment reflected several trends in American medicine and social and political structure. Medicine as a profession was developing into a structured and restricted field, and the examination and licensing of physicians was part of that development. Citizens were looking to government for protection from greedy and unscrupulous entities and individuals. Government was accepting increasing responsibility for the welfare of its citizens, and oversight and control of the individuals attending the health of its citizens was part of that obligation.

The Board of Medical Examiners began as a small, rather informal organization. The population of Nevada was low, and the physicians to be scrutinized and regulated were few. The doctors often knew each other, either personally or by reputation, and when there were problems, they were often solved without legal action.

As Nevada changed, affected by population growth and urban expansion in the second half of the twentieth century, the Board, too, evolved. The practice of medicine has been altered by technological advancement,

medical progress, and modifications in the systems of health care delivery, and doctors have struggled to adapt to their changing circumstances. The oversight of physicians has become more complex in an increasingly critical and litigious society. Laws governing physicians and medical practice have also become more complicated.

Change has directed and defined the Board of Medical Examiners. The altered medical, economic, and social ideology, as well as the reality of a transformed and modernized nation and its inhabitants, has affected medicine in Nevada and the Board of Medical Examiners. Change is obvious in the Board's history. Events, motivation, consequences, reaction — the history of the Board is revealed in the written record, the statutes, meeting notes, letters, and newspaper reports. Those sources disclose the earliest history of the Board and medicine in Nevada. The study of more recent events, however, has the advantage of an additional resource: oral histories. With their virtues and their faults, the men and women who have served on the Board of Medical Examiners, physicians and public members, have breathed life into an institution. It is their words, their reflections and recollections, that truly convey the texture of that history.

Overview of American Medicine

American medicine, as a vocation and as a profession, is one angle of view to the past, and it offers a unique perspective on American history. Developments in science and technology, perceptions of health and illness, the creation of a profession, the changing roles of women in the home and society, and more, are revealed when the past is examined in the context of the medical profession.

Although often viewed as a barren expanse upon which the progress of European civilization would continue, the American continent was not an empty space. Native American people had lived there for millennia, often in populous urban localities. Like the landscape, the indigenous populations of the Americas were irrevocably altered by the arrival of European adventurers and settlers. Medicine and healing, in a variety of forms, existed before European contact.

The arrival of Europeans introduced alien diseases to which natives had no immunity. The results were disastrous for native populations. Estimates of the death toll vary; but some historians believe that, overall, as much as 90 percent of the native North America population was destroyed within two hundred years of contact.[2] The traditions of spiritual healing or herbal cures were no match for the virulent pathogens of yellow fever, scarlet fever, diphtheria, and smallpox — deadly biologic baggage that Europeans carried.[3] Smallpox was the most lethal of the bacteriological new arrivals. William Bradford, leader of the Plymouth colony, described the misery of dying Plymouth Indians:

> They fall into a lamentable condition as they lie on their hard mats, the pox breaking and mattering and running one into another, their skin cleaving by reason to the mats they lie on. When they turn them[selves], a whole side will flay off at once, as it were, and they will be all of a gore blood, most fearful to behold . . . they die like rotten sheep.[4]

Although native populations were drastically reduced in numbers and their society radically changed by contact, remnants

of native groups and culture survived. Some aspects of native medicine were incorporated by local healers into colonial medicine.

Early Healers

The newcomers themselves were not without health problems. Most were woefully ignorant of the locale in which they would make their new home, and they were unprepared to survive. Early settlers faced a time of "seasoning" as they adjusted to a new climate and unfamiliar living conditions. Although there was a certain level of immunity to endemic diseases, new arrivals were weakened by the long journey, a trip that could take as long as fourteen weeks under crowded conditions. Ship's provisions were often inadequate, providing poor nutrition; and there was the added hazard of exposure to infectious diseases in the confined quarters.

Once in their new home, emigrants faced hard labor, food shortages during the "starving time," and a more severe climate than they were accustomed to. In the early years of the Virginia colony the mortality rate was about 80 percent, with colonists succumbing to various fevers and intestinal ailments. The Plymouth Colony, established in 1620, lost about half of the Pilgrims over the first winter.[5] The primary cause for the high mortality in the early colonial ventures was susceptibility to disease because of inadequate nutrition and substandard living conditions.

Pain and suffering were a given in seventeenth century life, but efforts were made to alleviate distress. Home remedies and home care were the most common means of dealing with illness or injury; and the care of ailing and injured family members was part of household responsibilities. There was generally an extended kinship and community network to assist and advise with care of the sick, especially with childbirth and serious illness and death. Mothers passed on their favorite home remedies, training daughters for future care-giving. Many illnesses were described as fevers, and health care tended to focus on relieving that symptom.

By the early eighteenth century English patent medicines were available in America and British brand names became familiar to colonial consumers. Remedies like Anderson's Scots Pills, Bateman's Pectoral Drops, and Hooper's Female Pills could be purchased from a variety of sources such as printers, tailors, hairdressers, grocers, goldsmiths, booksellers, and apothecaries. The popularity of British medicinals continued through the Revolutionary period and competition from American-made products was negligible until the early nineteenth century.[6]

Medical knowledge and instruction was a common feature in colonial newspapers and almanacs; but the availability and distribution of printed material was limited, particularly in isolated settlements. Most information was passed by word of mouth, within families and communities. By the late eighteenth century, medical manuals were available, providing medical information and advice. One popular edition, *Domestic Medicine*, was reprinted thirty times and widely circulated through the 1850s.[7]

Domestic medical manuals focused on the practicalities of treating the sick, using clear, easily understood language, attempting to de-mystify medicine. Simple treatment was advised, and prevention, in the form of fresh air, exercise, and cleanliness, was recommended. The use of a physician was suggested only as a last resort. John Wesley's published work of 1747, *Primitive Physic*, denounced physicians, charging that ego and a desire for gain had resulted in an unnecessary mystification of medical practice,

to the detriment of the patient.[8] Physicians would work to eventually overcome such persistent distrust as they organized to create a respected profession.

When home remedies failed, some sort of medical practitioner could generally be found. Local clergy, normally the best educated individuals in a community, were frequently called upon to attend the sick; some formalized their dual roles and about 15 percent of the early members of a New Jersey medical society were "pastor-physicians." Midwives were often local healers and specialized in a variety of ailments and medicines. Mrs. Hughes, who advertised her services as a midwife in Virginia in 1773, could also cure ringworm, piles, worms, and sew fashionable dresses and bonnets.[9]

Martha Ballard was a midwife practicing in eighteenth-century Maine. Over the course of three decades, she gave birth to nine children of her own and helped 816 others into the world. Her diary reveals that she had extensive knowledge about the treatment of diverse illnesses and was as likely to treat "flying pains" or the "salt rhume," as to deliver a baby. She covered a large territory and braved bad weather and arduous travel conditions to reach her patients. Mrs. Ballard was often away from home for several days to attend a birth. She never retired from her profession and attended a delivery the month before she died. Although there are not other extant journals such as Ballard's that record twenty-seven years of a midwife's life, Martha Ballard was undoubtedly typical of many women practicing medicine and midwifery in eighteenth and nineteenth century America.[10]

Physicians diagnosed patients by observing their symptoms, such as rash or fever, then attempted to treat those outward signs of illness. Understanding of disease was based on a variety of theories, but purging, bleeding, sweating, blistering, and vomiting were the common treatments of choice for physicians.[11]

Smallpox was endemic among the colonial European population and an early medical controversy, pitting physician against clergy, erupted over the issue of smallpox inoculation. Smallpox epidemics were cyclical, spreading through susceptible populations every few years. In the seventeenth century there were major outbreaks in New England in 1634, 1638, 1648-49, 1666, 1675, 1685-86, 1689-90, and 1692.[12] The plague of smallpox was devastating to infected towns: businesses closed; public assemblies were banned; ships refused to come into port, resulting in economic loss and food shortages; and the loss of heads of households left many families destitute.[13]

In 1721 smallpox came to Boston on a ship sailing from the West Indies. Though efforts were made to isolate the ship and crew, the dreaded disease spread rapidly and almost half the city's population was eventually infected. A dispute over inoculation experimentation arose between prominent clergyman Cotton Mather, who had pursued a lifelong interest in medicine and scientific inquiry, and Dr. William Douglass, a distinguished Boston physician. The argument divided the medical community. As the debate escalated, physicians united, forming the Society of Physician Anti-Inoculators. On the other side were the clergymen, who supported Mather's position, contending that inoculation was "the gracious Discovery of a Kind Providence to Mankind." There was violence when a bomb, which failed to explode, was thrown through a window in Mather's house.[14]

The epidemic died down by spring of 1722 with no resolution over the issue of inoculation. Beyond health care issues, the debate over inoculation is significant

because of the insights it provides into a crisis of status that was occurring in colonial America. As noted previously, clergy had often been responsible for the physical as well as the spiritual well-being of their flocks. As the population of the colonies increased, however, more physicians were practicing, attempting to build a clientele and establish their position as medical authorities. Dr. William Douglass was the sole physician among Boston's doctors to have a medical degree; the intervention by clergyman Mather was a threat to Douglass's position.[15] The Boston inoculation controversy is only one of the struggles that physicians waged in efforts to establish their authority and control over medical matters.

Echoes of the conflict reverberate across 250 years of American medical history as physicians fought to gain and hold their territory. The issues and the individuals involved changed over time, as did the locations where battle lines were drawn. The basis for one protracted campaign was established in the early nineteenth century, when the issue of medical diversity first emerged. It was a controversy that would erupt in Nevada in both the nineteenth and twentieth centuries, an issue that is still debated.

Medical Diversity

Medicine in early nineteenth-century America offered a medical mélange for the relief of suffering. Generally referred to as the "irregulars" or "sectarians" in contrast to the "regulars" or "allopaths" of mainstream medicine, a variety of healers embraced a plethora of approaches to curing sickness or maintaining good health. The demand for choice in health care was sufficient to provide active competition to regular medicine for most of the nineteenth century.

As in earlier times, many people continued to use traditional folk remedies, relying on apothecaries and herbalists for customary nostrums, and midwives for birth and female troubles. Family remedies were still passed down and medical manuals consulted. A good number of Americans, through choice or circumstance, avoided physicians unless the illness was serious or other treatments had failed.[16]

In the early decades of the nineteenth century the enthusiasm and belief in mankind's perfectibility that had created a new nation and new system of government, led many Americans to focus their attention on the sundry afflictions of society. While believing that the world could be a better place, some limited their concern to a tiny corner of the world and moved into isolated communities, based on religious or socialist beliefs, and organized their vision of a perfect world. Others centered on strong drink as the source of suffering and misery and campaigned for moderation or total abstinence. Some reformers worked to eradicate the evils of slavery, others labored to gain basic social and political rights for women.

For many, the human body, its good health and effective function, was the source of their concern and attention. Decades after these first health reformers, Mark Twain would look back facetiously at them, and at his contemporaries who were their ideological descendants, describing an adherent as one who "eats what he doesn't want, drinks what he doesn't like, and does what he'd druther not, all the while smugly announcing himself to be energetic, joyful, and certain of long life."[17] Twain's scornful observation had some merit. While there was value and positive effect in many of the health movements of the antebellum period, it was also a period rife with quackery when consumers fell victim to

extravagant claims that could do more harm than good.

Some reforming medical notions were the basis for sects that challenged, with more and less success, the regular practice of medicine. The three most influential, the Thomsonians, the homeopaths, and the eclectics, filled a gap left by regular medicine and put traditional medicine on the defensive, thereby contributing to the emergence of medicine as a profession.

By the early nineteenth century the practice of heroic medicine, "bleeding, purging, and puking,"[18] with the occasional blistering thrown in, was established as the core of medical treatment by regular physicians. Doctors often used heavy doses of calomel, mercury, opium, and other potentially lethal medications to treat a variety of ailments. Heroic medicine continued through much of the nineteenth century although the intent of the aggressive intervention changed. Early heroic medicine has been termed depletive therapy, reflecting its goal of restoring balance, and health, by cleansing the system. Later heroic therapy used familiar drugs but focused on the alleviation of symptoms. The utilization of heroic therapy differed with physician and geographical region. It was employed through most of the nineteenth century but its use, particularly venesection (bleeding), declined over the century.[19]

Americans turned to assorted medical theories in the search for relief of their aches and pains. The sectarian schools of medical practice that emerged from these alternative beliefs provided competition for mainstream medicine well into the twentieth-century.

Samuel Thomson was a self-made man who turned his dissatisfaction with heroic medicine and his observations of the medicinal properties of plants into a business and a medical sect. With no formal training, Thomson began his practice of medicine around 1800. He developed the theory that hot was life and cold was death; when food was not digested properly, the body stopped producing heat and sickness resulted. To restore health, the system must be cleared so that food could be effectively processed and the necessary heat generated. A specific course of treatments with simple plant-based medicines, emetics, teas, and tonics was designed and marketed by Thomson.[20]

The title of Thomson's book, *New Guide to Health: or, Botanic Family Physician, containing a Complete System of Practice, on a Plan Entirely New; with a Description of the Vegetables made use of, and Directions for Preparing and Administering Them, to Cure Disease, to which is Prefixed a Narrative of the Life and Medical Discoveries of the Author*, provided a relatively complete explanation of his intent. Those who purchased the guide would be able to cure their illnesses, using easily concocted medicines based on common plants.

Thomsonian methods were extremely popular, especially among those Americans living in frontier or rural areas with limited access to physicians, as well as among poor urban dwellers who could not afford to pay for medical care. Although regular physicians disparaged Thomson's therapies, the system was widely used in the first half of the nineteenth century. Much of what Thomson advocated was familiar to people accustomed to home remedies and folk medicine, and provided an acceptable alternative to seeking the doubtful aid of an expensive and often distrusted regular physician.

Unlike the grassroots basis of the Thomsonians, the homeopathic doctrine of healing was imported, based on theory developed in the early nineteenth century by a German physician, Samuel Hahnemann.

Hahnemann's philosophy evolved from his acceptance of the belief that symptoms comprise disease and disease can be cured with the elimination of symptoms. Experimenting with the effects of drugs, Hahnemann dosed himself with cinchona bark and noted that, used on a healthy individual, the drug caused malaria-like symptoms. He concluded then that "what causes illness in a healthy person will cure the same illness in a sick person."[21] This law of like curing like, *similia similibus curantur*, was the basis for his homeopathic theory of medicine.

With further experimentation Hahnemann deduced that large doses of drugs masked the effects of the medication. His solution to that problem was to reduce, drastically, the concentration of drugs. By the end of his life in 1843, Hahnemann was advocating diluting to the thirtieth power, an infinitesimal dose.

Homeopathic medicine was brought to the United States in 1825. Its popularity spread slowly but by 1850 a homeopathic medical college was established in Ohio.[22] In contrast to Thomsonians, who generally distrusted regular medicine and physicians and found most of their support among rural folk and the urban poor, homeopathic medicine was generally adopted by regular physicians who practiced among the urban middle and upper classes. The lay medical practice of the Thomsonian movement, among other medical theories, had little attraction for more affluent Americans who were comfortable seeking (and could pay for) medical care from educated men of their own class.

Nineteenth century physicians, both irregular and allopaths, tended to use what they thought effective in their practice. The founder of the eclectics, Wooster Beach, looked to Thomsonians, native medicine, herb doctors, and others for alternatives to heroic therapy. Beach, who founded a New York infirmary in 1827 and later turned it into the Reformed Medical Academy, called his program eclectic because of the variety of medical tenets it borrowed. Eclecticism itself had no clear system or precepts; though its adherents tended toward the use of botanic medicine, in the antebellum period they emulated regular medicine with heroic doses of botanics rather than minerals.[23]

The sect declined around the time of the Civil War, but was revived in the 1870s by a successful eclectic practitioner, John Scudder. Scudder, like the homeopaths, advocated small doses of botanic medicine, labeling his system "specific medication." Unlike the homeopaths, eclectics were not restricted to "like cures like," and a great variety of remedies, created empirically, were marketed commercially. Scudder also emphasized that harsh medication must be discarded and the stomach and the patient kept comfortable. The eclectic sect found it difficult to articulate an ideology that effectively distinguished them from other schools of medicine. Scudder maintained that "your sound Eclectic today believes in small doses of pleasant medicines for direct effect. He takes his remedies from every source."[24]

A number of eclectic medical schools were established and the sect was most popular in small towns in the Midwest, where most of its adherents trained and practiced. Eclectic physicians often had an unfavorable reputation: many were obvious charlatans, especially in the antebellum period. Practitioners frequently came from the poorer classes and tended to have an inferior medical education. When other medical schools raised their standards, the eclectic colleges, operating on the margin, could not take any steps that would deter

potential students. The enrollment of 1000 eclectic medical students in 1904 had declined to 256 by 1913. Thus the sect dwindled in the early twentieth century, as most practitioners were absorbed into allopathic medicine.[25]

Establishing a Profession

In rapidly industrializing post-Civil War America, there was a trend toward professionalization among a number of occupations. Organization by profession or trade was facilitated by improved transportation and communication. In part it was a response to the need for a knowledgeable, management-level work force in a more complex technological society. The loss of individual power to corporate structure was a factor in organization. But it was also an effort to raise standards, status, and income by limiting the numbers of individuals eligible to participate legally in specific fields.

Doctors practicing allopathic medicine were among those groups who tightened their ranks by requiring certain educational standards, examinations, and licenses.[26] They faced a difficult task. In the era of heroic medicine, allopathic physicians were distrusted by many, and there was vigorous competition from sectarian medicine. From the 1830s forward, there was a proliferation of medical schools; a phenomenon that one medical historian has labeled "medical school mania."[27] A shift to proprietary schools[28], with a commercial orientation, produced large numbers of undertrained and untrained individuals who simply hung out a shingle and went to work.

Reform of medical education was a key to raising standards in medicine, and the improvement began with Harvard and Johns Hopkins. The medical school at Johns Hopkins was established in 1893, and was the first American medical school to require a college degree. The American Medical Association (AMA) had been founded in 1846 but was relatively powerless as a national organization until around the turn of the century. In 1901, with membership down to 8000 members, the AMA reorganized, becoming, with its new structure, a confederation of state medical societies. The new order was effective, and by 1910 about half the doctors in the country, 70,000, belonged to the AMA.[29]

In the first decade of the twentieth century the AMA supported educational reforms and helped establish minimum standards for education. The Council on Medical Education, permanently established in 1904, was part of that effort.[30]

Although concerned about the quality of medical schools, the AMA could not violate its own code of ethics with public criticism of other physicians. The Carnegie Foundation for the Advancement of Teaching was encouraged by the AMA to investigate the status of medical schools. In 1910 a report prepared by Abraham Flexner, an educator and graduate of Johns Hopkins, was published based on his survey. Flexner scrutinized all the medical schools in the U.S., and was ruthless in his analysis and scathing in his appraisal.

He found proprietary schools with phantom laboratories and libraries. Instructors were in private practice and ineffective or unavailable. Schools were willing to waive entrance requirements for those students able to pay fees. Flexner noted that there was a great gap between medical science and medical education.[31]

The report had a profound effect on medical education. Medical schools had been improving the quality of medical education. The numbers of schools had continued to rise in the 1880s and 1890s, but had started to decline by the first decade of the twentieth century. Physicians and educators had been

aware of the poor condition of medical education, and Flexner's commentary served as a catalyst for action. In the aftermath of the Flexner report, many more medical schools either consolidated or went completely out of business. When the report was published, there were 131 medical schools operating; by 1915, that number had dropped to 95.[32] Flexner's work also helped convince John D. Rockefeller to contribute almost $50 million to the General Education Board toward the betterment of America's medical schools.

Medical education became more effective and more uniform, contributing to a rise in status for physicians. This uniformity also undercut sectarian medicine and helped to consolidate the hold of the allopaths. In addition, some sectarian schools were incorporated by allopathic institutions, further diminishing diversity.

Medical licensing requirements had spread rapidly in the late nineteenth century, and by 1901 all states and territories had some sort of legal requirement for medical practice.[33] The standards and requirements were continually elevated, contributing to the exclusivity and professionalization of medical practice. The pattern of organization, restriction, and raising of standards is one that was followed in Nevada, as medical practitioners endeavored to professionalize, and is discussed in Chapter Three.

Organization also made it easier to limit membership in the profession. Although it helped keep out incompetents and quacks, the new professionalism was a double-edged sword that could also be used against women and minorities.

Women and the Minorities in Medicine

Women have long been associated with healing; as noted earlier, the care of the sick was a part of female household and community duties. Although the tradition of a woman as a village healer was widespread and abiding, the most common professional function of woman as healer was that of midwife.

Women in the nineteenth century, however, were interested in moving beyond traditional, private roles as healers. Trained women physicians, though uncommon and a small percentage of the medical field, began to move into the public sphere. In 1835, the Hunt sisters, "female physicians," established their practice in Boston. Like most of their male colleagues, Harriot and Sarah Hunt had gained their medical training through an apprenticeship. Elizabeth Blackwell was the first woman to receive a medical degree from an American school, Geneva Medical College in 1849.[34]

Although women managed to overcome obstacles to their participation in the medical field as physicians, throughout the nineteenth and most of the twentieth centuries they remained on the fringes of the profession. The promising gains to provide medical education for women were never fully realized. A number of medical colleges for women were established after the Civil War, but these were underfunded and operated on the edge of success. By the turn of the century, women were attending coeducational institutions, but always in low numbers. Most confronted resistance and discrimination.[35]

Once graduated, female physicians were commonly barred from participating in the professional network that facilitated medical practice. They often found placement in the less important internships and hospital appointments. Women physicians constituted about 4 to 5 percent of the profession around the end of the nineteenth century, and that percentage did not significantly increase until the 1960s.[36]

Racial minorities were discriminated against in medicine as in other professions and trades. In the decades after the Civil War black education was promoted, and medical education was part of that advancement. The first black medical college was Howard University in Washington, D.C., which was established in 1867. Almost ten years later, Meharry Medical College was founded in Nashville.

Black hospitals were created as a response to segregation faced by black patients and physicians. Nearly 100 such institutions had been established by 1910, and they provided internship and residency opportunities for blacks doctors who were excluded from most programs.

In the twentieth century, as medical education was reformed it also became more expensive. This created a barrier for blacks and other minorities wishing to enter medical professions. World War II changed the situation somewhat as more blacks were commissioned as medical officers. In the postwar period blacks managed, with government help, to make their way into more medical programs. It was the civil rights legislation of the 1960s, however, that truly opened the doors to blacks and other minorities. Many more blacks, both men and women, were able to enter the medical professions in the last decades of the twentieth century.

Other minorities have encountered discrimination similar to that faced by women and blacks. Economic limitations are often a factor, but ethnic and religious bigotry and bias are also a consideration. Discrimination and prejudice always exist to some degree; but the institution of federal laws guaranteeing equal opportunity has worked to open doors for a number of groups, whether characterized by race, gender, or ethnicity.

Twentieth-Century Medicine

The United States experienced tremendous social, economic, and technological change in the decades after the Civil War. With industrialization and urbanization, public health was an issue with which government and the health profession were forced to contend. A rising birth rate and increased immigration contributed to overcrowding in the cities. Health problems resulted when water and sanitation facilities proved inadequate for the rising population density. Mechanization on farms improved agricultural output but increased the incidence of serious accidents.

Technology brought about extraordinary alterations in lifestyles as America was electrified, beginning in the 1880s, in the cities first and gradually spreading out into the countryside. There were improvements in sanitary facilities, and indoor plumbing was a boon to human health. By 1900 the Bell Telephone Company had installed 800,000 telephones in the U. S. The telephone made it easier to call a doctor and to obtain information, and help, more quickly. Better roads and the automobile eased the physician's burden in getting to his patients quickly and safely.

Hospital care developed and expanded in the late nineteenth and early twentieth centuries. Almshouses and charity facilities were transformed into hospitals, and new hospitals were built. Tuberculosis sanitoriums emerged in the early twentieth century, particularly in the Southwest, where patients were treated with rest, fresh air, and food. Surgical procedures were more commonly and more safely performed in hospitals as the use of anesthesia was modified and improved.[37]

The financial aspect of health also changed in the twentieth century, and a larger segment

of the American population gained access to physicians and health care. As part of their reform effort, the Progressives of the pre-World War I period advocated health insurance, but lost their program to resistance by the medical establishment.[38] Rising medical costs of the 1920s and the financial distress of the 1930s, however, forced the institution of private health insurance. By the late 1950s, almost two-thirds of Americans had hospitalization coverage.

Organized medicine had vigorously, and usually successfully, resisted efforts toward government sponsored health care programs, fearing that it would undercut their status and economic position. The crisis of the Great Depression, however, was a catalyst for expansion of federal responsibility for medical care; many of the New Deal agencies had been involved in some aspect of public health. The Social Security Act of 1935 extended government involvement in health care, in part by providing a mechanism for allocating federal money to health programs. The Wagner bill, a law that would have established a national health program, failed in 1939, in part because of opposition by the medical establishment.[39]

In 1958 a proposal was made for a program to cover the hospital costs of Social Security recipients, but a campaign launched by the AMA worked to defeat any attempt at government intervention in private medical care. In large part it was the assassination of President John Kennedy that provided the impetus for passage of a massive government program aimed at improving the quality of life for poor Americans. Medicare was part of President Lyndon Johnson's Great Society and was passed in 1965. This was an amendment to the Social Security program, providing government financed insurance for Social Security recipients.

Beyond insurance plans and federal programs, there has been a trend for change in the organization of medicine that has affected the physician more personally. The emergence of group and corporate practice has become the most common structure for medical practice. The increasing complexity and expense of practicing medicine, as well as a desire to reduce the number of hours worked, has propelled physicians into partnerships. The development of health maintenance organizations and the managed care approach to medical practice also radically altered medical practice.

By World War II medicine was a respected profession. Technological and scientific advancement, however, did not come without a price. Physicians have experienced remarkable and rapid change in the practice of medicine. The long history of medicine in America forms a context for the recent history of medicine in Nevada — and the creation and development of the Nevada State Board of Medical Examiners.

Notes

1. Quoted in Richard Harrison Shryock, *Medical Licensing in America, 1650-1965* (Baltimore: The Johns Hopkins Press, 1967), vii.

2. Gary Nash, *Red, Black and White: The Peoples of Early America*, 2d ed. (Englewood Cliffs, N.J.: Prentice-Hall, 1982), 17.

3. Nash, 60.

4. Quoted in David Freeman Hawke, *Everyday Life in Early America* (New York: Harper & Row, 1989), 81.

5. John Duffy, *The Healers: A History of American Medicine* (Urbana: University of Illinois, 1979), 9; James H. Cassedy, *Medicine in America: A Short History* (Baltimore: Johns Hopkins, 1991), 4; Jerome D. Reich, *Colonial America* (Englewood Cliffs, N.J.: Prentice-Hall, 1984), 69.

6. James Harvey Young, "Patent Medicine and the Self-Help Syndrome," in *Sickness and Health in America*, ed. Judith Walzer Leavitt and Ronald L. Numbers (Madison: University of Wisconsin Press, 1985), 72.

7. Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 32.

8. Starr, 33-34.

9. Cassedy, 10; Starr, 39-40.

10. Laurel Thatcher Ulrich, *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812* (New York: Vintage Books, 1990), 9-33.

11. William G. Rothstein, *American Physicians in the 19th Century: From Sects to Science*, originally published 1972 (Baltimore: Johns Hopkins University Press, 1985), 27; Duffy, 28.

12. John Duffy, *Epidemics in Colonial America* (Baton Rouge: Louisiana State University, 1979), 43-48.

13. Joel N. Shurkin, *The Invisible Fire* (New York: G.P. Putnam's, 1979), 146.

14. John B. Blake,"The Inoculation Controversy in Boston: 1721-1722," *The New England Quarterly* 25 (December 1952): 493-494.

15. J.J. Barrett, "The Inoculation Controversy in Puritan New England," *Bulletin History of Medicine* 12 (1942): 172.

16. Cassedy, 33-34.

17. Mark Twain quoted in James C. Whorton, *Crusaders for Fitness: The History of American Health Reformers* (Princeton: Princeton University Press, 1982), 3.

18. Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985), 29.

19. John Harley Warner, *The Therapeutic Perspective* (Cambridge: Harvard University Press, 1986), 91-97; for detail about medical therapeutics of the nineteenth century, also see Morris J. Vogel and Charles E. Rosenberg, eds., *The Therapeutic Revolution: Essays in the Social History of American Medicine* (Philadelphia: University of Pennsylvania Press, 1979).

20. Discussion of the 19th century medical sects that challenged regular medicine, Thomsonians, homeopaths, and eclectics, is based primarily on William G. Rothstein, *American Physicians in the 19th Century*.

21. Rothstein, 153.

22. Starr, 97.

23. Rothstein, 217-219.

24. Quoted in Rothstein, 228.

25. Starr, 107.

26. Nineteenth-century professionalization is examined in Burton J. Bledstein, *The Culture of Professionalism: The Middle Class and the Development of Higher Education in America* (New York: W. W. Norton & Co., 1976); for more on the specific professionalization of medicine, see Joseph F. Kett, *The Formation of the American Medical Profession* (New Haven: Yale University Press, 1968), and Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

27. Ronald L. Numbers, "The Rise and Fall of the American Medical Profession," Leavitt and Numbers.

28. Proprietary medical schools were established for profit and status. The profit motive resulted in a profusion of schools, many of them poorly staffed and equipped. Admission standards were lowered or waived to attract more students, and medical education declined.

29. Starr, 109-110.

30. Robert P. Hudson, "Abraham Flexner in Perspective: American Medical Education, 1865-1910," Leavitt and Numbers, 152.

31. Starr, 119-120.

32. Starr, 118-120.

33. Starr, 104.

34. The most complete discussion of women physicians in America is found in Morantz-Sanchez, *Sympathy and Science*. The obstacles that the medical profession raised to limit the participation of women in medicine are explored in Mary Roth Walsh, *"Doctors Wanted: No Women Need Apply," Sexual Barriers in the Medical Profession, 1835-1975* (New Haven: Yale University Press, 1977); Walsh, 1; Morantz-Sanchez, 64.

35. Nevada's first female physician, Dr. Catherine Post-Van Orden, was practicing in Treasure City, in White Pine County, in 1870. See Anton P. Sohn, M.D., "The Acceptance of Women Physicians in 19th-Century Nevada," *Greasewood Tablettes* 6, no. 2 (Summer 1995).

36. Walsh, xviii; Morantz, 17.

37. Cassedy, 68-75.

38. This overview of changes in 20th century medical structure is based primarily on the analysis in Starr, *The Social Transformation of American Medicine*, Book Two, Chapters Two, Three, & Four.

39. Duffy, 317.

2

Medicine in Nevada and the West

Nevada embodies many of the characteristics of the West. As in other Western areas there are mining communities, ranches, small towns, and urban areas. Historically, Nevada has been part of the Overland Trail, and the quest for rich land and even richer mining strikes. The West of the imagination, abundant in imagery and myth is part of Nevada: cowboys and Indians, the railroad, boisterous boom towns, shady ladies, and a vast, overwhelming landscape.

There is also, however, much that is singular about Nevada. A dearth of natural resources in an arid region has prompted unusual solutions to economic problems. Legislated industry has garnered approbation and condemnation. The presence of the federal government, which owns 87 percent of the land within the state's boundaries, has influenced the course of the state and its citizens.

The characteristics of life in Nevada, differing over time and by place within the state, have influenced medicine in the Silver State. The demands of the profession and the people who practice medicine have been affected by national trends, have been part of regional variations, and occasionally have been atypical. In short, medicine in Nevada has been as diverse as the state itself.

Western Medicine: The Regional Perspective

American medicine made tremendous advances in the late nineteenth century. The progress, however, was based to a large extent on a technology that was dependent upon laboratories to facilitate diagnosis, modern hospitals to provide patient care, and well-trained physicians to diagnose and treat. That infrastructure was lacking in the American West and the quality of medical care in the West was inferior to that in the East, about a half century behind the times.[1]

The most serious lack was that of competent, modern physicians. Those who had a better education and training than average, particularly if they had trained in Europe, tended to stay in the East, where

more prosperous practices could be built. The majority of the physicians who practiced in the West either had diplomas from proprietary schools, with limited requirements and education, or had served a brief apprenticeship. Others simply appropriated the title of doctor and hung out a shingle.

Skilled physicians were rare in the West, in part because it was difficult to make a living in cash-poor and often impoverished communities. If money was scarce, however, disease was not. As with the earliest settlers along the eastern seaboard, malaria plagued pioneers as the frontier moved west. It was particularly virulent in the earlier West of the Mississippi Valley but was also a threat in valleys and lowlands of the Far West.

It was an unfortunate happenstance that the rush west in 1849 coincided with a national epidemic of Asiatic cholera. This deadly and highly contagious disease came overland with wagon trains and around the Horn on ships. Living conditions in the boom towns in California's gold country were crowded and unsanitary, and cholera moved rapidly through the population. When it swept though Sacramento in 1850, it is possible that it carried away 1,000 of the city's 6,000 residents.[2]

Because of the scarcity of doctors, travelers and those already settled relied on self-medication for illness and mishaps. The common remedies kept on hand reflected the heroic medical thinking that often prevailed: calomel, jalap (a purgative), quinine, blue pills (a form of mercury), ipecac, peppermint, and some form of an opiate. Onions, mustard, turpentine, lard, eggs, sugar, goose grease, manure and other household and barnyard staples were used in poultices and home remedies that were "rubbed on, inhaled, bathed in or ingested." Whiskey, straight from the bottle or disguised as a tonic, was also favored.[3]

Medicine and illness differed somewhat by region, population, and economic base, but there was much that the transient population would find familiar as they moved around the region. That was the case in Nevada, with miners moving in from California or Colorado, farmers coming from Nebraska or Idaho, or graziers from Texas or Arizona. There was a great deal about Nevada and Nevada medicine that was common to the rest of the West.

Life on the Mining Frontier

Medicine in nineteenth century Nevada presented a challenge to the physicians who followed the miners and ranchers to the state, and many obstacles to efficient and effective medical care continued into the twentieth century. Because of the boom-and-bust character of Nevada's economy, physicians who set up practice in a flourishing community one year could find themselves packing up the next year and following other citizens on to succeeding gold, silver, or copper discoveries and the new town that established itself around the mines. The landscape was generally inhospitable and the living conditions initially primitive, with limited sanitary facilities. Disease thrived in crowded mining camps, and hard rock mining was a hazardous occupation. Physicians dealt with epidemics and crushed and severed appendages in the less than ideal circumstances of mining boom towns.

Ranching and farming enterprises in Nevada were established in isolated areas of the state, and medical facilities and physicians were scarce. Because of the aridity of the Great Basin it took vast acreage to run cattle or sheep successfully, and rural Nevada tended to be even more rural than similar operations in more eastern areas of the country.

The first white settlement in Nevada grew up around a supply center for emigrant trains making their way west. By 1850 a trading post had been established in the Carson Valley, an advantageous site to serve California-bound travelers. The same year the post was settled, gold was found in an area not far from the trading location. For the next few years miners worked the area, appropriately dubbed Gold Canyon. Larger and more significant discoveries were made in the district in 1859, and the famous "rush to Washoe" was on as miners reversed their westward charge. Crude communities were erected, and Virginia City, Gold Hill, and Silver City were the sites of frenzied activity in the often frantic search for precious metals.

With the discoveries of vast mineral deposits, Virginia City became a bustling, cosmopolitan town, sprawling at the base of Mount Davidson. Historian Russell Elliott characterized it as "one of the wonders of western America, a place that had to be seen to be believed."[4] The inhabitants were a complex mix of races and nationalities, including the famous, the obscure, the destitute, and the fabulously rich. They lived in grand mansions, tidy frame houses, canvas tents, and back-street cribs. They were entertained by the circus, in an elegant opera house, less-than-gracious saloons, by the wit of Mark Twain and the talents of Julia Bulette. Engineering marvels facilitated life in an inhospitable environment and brought water to the arid community, shored up the enormous cavities they excavated, and wrapped a railroad around the mountain so the treasure yielded by the Comstock could be delivered to the outside world. The "Queen of the Comstock" did indeed need to be seen to be believed.

The grandeur of the past and the rhythm of everyday life can be found in the words of many who sojourned in Virginia City, documenting their experiences, relating impressions and events in letters, journals, and autobiographies. Aches, pains, and illness were of great interest in most people's lives and their health and medical problems were often recorded in some detail.[5]

Mary McNair Mathews lived in Virginia City for almost a decade in the late 1860s and 1870s. A widow, she supported herself and her son by taking in sewing, doing laundry, nursing, child care, and running both a school and a boarding house. Mrs. Mathews wrote her memoirs, expressing definite opinions about the town, the people she met, and the medical profession. She recalled a time when her son, Charlie, "commenced to act as if he was sick." Charlie was indeed ill, with scarlet fever, and Mrs. Mathews nursed him. When his condition worsened, she refused to call a doctor, informing a neighbor that she "could not think of trusting his life in another person's hands." Even when Charlie hovered between life and death, his cautious mother refused a doctor:

> Mrs. Beck again urged me to get a doctor; said the children were dying all over the city. That is just why I do not get one; I am afraid they could not cure him. I was a good nurse, and I thought if anyone could save him, I could, for I knew his constitution better than anyone else.[6]

Charlie survived that crisis and others. He severed one finger completely and another partially while playing with a hay-cutter. Mrs. Mathews "was persuaded, against my will, into getting a doctor." She disregarded his advice to amputate the remaining finger and followed her own course of treatment, applying burnt alum to the "proud flesh,"

and Charlie's finger was saved. In an example of folk belief, she preserved the end of the severed finger in brandy. As she explained, this would "prevent his finger ever bothering him after it had healed up."[7]

Mrs. Mathews's distrust of physicians was shared by many of her contemporaries. As was common in the nineteenth century, residents of Virginia City and other Nevada communities self-treated and turned to alternative medical care for their ailments. The *Territorial Enterprise* was an effective directory of the services available: Dr. J. H. Josselyn had an Electropathic Institute and, as his advertisement indicated, the enviable record of only eleven failures out of twenty-five thousand consultations. Advertising below him was Dr. Hop Lock, a Chinese physician; on the same page was Dr. Doherty of San Francisco, who offered cures for Spermatorrhea and other diseases related to impotence and virility.

For those who did not want to visit a physician, Hostetter's Celebrated Stomach Bitters would cure dyspepsia, liver complaint, sick and nervous headache, constipation, colic, intermittent fevers, sea sickness, cramps and spasms, and several other maladies. Newell's Pulmonary Syrup, which would cure coughs, colds, sore throats, asthma, whooping cough, bronchitis, and consumption, came with certificates "from many prominent citizens of San Francisco."

The ingredients of patent medicines could be lethal. Alcohol and opium were common components of the soothing syrups and teething cordials that were given to fretful children. Nationally, concern was expressed over the addictive qualities of patent medicine and its overuse; paregoric was commonly referred to as the "nemesis of the nursery" because of its abuse. In Virginia City, however, if both doctor and nostrum failed, J. W. Wilson was to be found on South B Street and had a "fine hearse and carriages" as well as "Barstow's Patent Metallic Burial Casket."[8]

The Storey County Hospital opened in 1865, and a second medical center was established a decade later. St. Mary Louise Hospital, lauded as the first modern such institution in Nevada, was built in Virginia City in 1876 to serve the rapidly growing community. The land for the building was donated by Marie Louise Mackay, wife of the wealthy Comstock entrepreneur, John W. Mackay, and Mr. Mackay provided much of the funding for construction of the hospital. Miners paid into a union hospital fund, one dollar per month, and utilized the services of the hospital on a prepaid basis, a form of health insurance. St. Mary Louise Hospital was staffed with a resident physician and administered by the Daughters of Charity, who kept the facility open until 1897. By that time the population of Virginia City had declined to the point that it was difficult to support the hospital, and the sisters left to answer another call, that of the impending Spanish-American War. There were other medical facilities in the state — in 1875 a county hospital and poor farm had been founded in Reno — but in the 1860s and 1870s the towns of the Comstock were the center of Nevada's population.[9]

Mining was hazardous work, and the men who spent their days underground faced the hazards of cave-ins, flooding, poison gas, heat, scalding water, dangerous heavy equipment, and fire. Mine owners were sometimes forced to relieve miners after fifteen-minute shifts because of the heat. One early historian of Nevada calculated that as much as ninety-five pounds of ice per man would be used on an eight-hour shift. As the mines forged deeper into the mountain, workers were lowered for their shifts on open platforms and many were

killed or maimed when they fell into the shaft or were crushed in the mechanism. In 1869 a fire in the Yellow Jacket mine killed forty-five men and injured many others.[10]

Reports of the deaths and injuries of miners were a common feature in the newspapers of Virginia City and other mining community newspapers. In March of 1867 the *Territorial Enterprise* reported the passing of John Brown, whose dead body "was found in what is known as the old Chollar-Potosi shaft . . . He is supposed to have fallen a distance of 250 feet, or from the first level; the shaft is 480 feet deep."[11]

Prostitution was as much a part of western mining communities as the miners themselves, and Virginia City was no exception. Transaction of the "oldest profession" expanded physicians' practices. The life of a prostitute was hazardous; physical abuse, alcohol and drug abuse, venereal disease, and pregnancy were constant threats to the women's livelihood and health. The standard methods of birth control for the time — rhythm, *coitus interruptus*, and condoms — were obviously impractical. Alternatives such as pessaries, vaginal sponges, cotton tampons, suppositories, and douches were used; but they too were unreliable. Some methods, such as douching with carbolic acid, were dangerous.[12]

Abortion, although illegal in Nevada after 1869, was sought by both prostitutes and "respectable women." Mechanical abortions were done with coat hangers, knitting needles, or crude catheters. Though dangerous, they were less so than chemically induced abortion, which women could obtain through newspaper advertisements that promised relief for "female complaints." One female physician visiting Virginia City in 1877 was questioned by a coroner's jury when a patient she had examined died trying to abort a fetus. Dr. M. M. Cowan had been in town caring for the butcher's wife, and she managed to convince the jury that she was not involved with the abortion despite the suspicious fact that a syringe and speculum with a vaginal tube were found in her medical bag.[13] Criminal charges could have been brought against Dr. Cowan, as abortion was legal only to save the mother's life.[14]

Venereal disease was also a threat to women's health, and not limited to mining communities or prostitutes. Although the working girls were at greater risk than married women simply by virtue of the diversity of their sexual contacts, married men who frequented brothels could, and did, bring home a variety of diseases.

Nationally, reported cases of syphilis, gonorrhea, soft chancre, venereal warts, and herpes increased dramatically after the Civil War. Physicians in Virginia City advertised "discreet cures" and "infallible remedies." When the infallible remedies failed, physicians resorted to surgical removal of the affected body part. Journalist Alf Doten recorded in his diary one unfortunate's loss of two inches of his penis, which was rotting with "pox." The physicians themselves were not always exempt from the "private diseases" that they attempted to cure: Dr. C. C. Green, who treated prostitutes on the Comstock, ended his life in an asylum, a victim of venereal disease.[15]

Alf Doten, who was a sometime miner and man about town in addition to his journalistic bent, left extensive documentation of his life in Nevada. Amidst his mining wheeling and dealing and adventures with other men's wives, Doten revealed much about everyday life, the tragic and the trivial, on the Comstock and other mining communities. Doten moved his family to Austin in 1883, where he worked on the editorial staff of the Reese

River *Reveille*. While living there he recorded his care of his wife when she was ill while pregnant:

> [Mary's] trouble culminated in a miscarriage about 1 1/2 oclock — Baby boy, about 8 inches long, perfectly formed — Mother & I stood in & helped Mary through as best we could — Then sent for old Jane Noble & Dr. Hammond — Both came & staid till morning — I got no sleep — The little fellow was born dead — Shortly afterward I fired up my furnace again and cremated him — *God Help us all* —

Mrs. Doten was seen by a physician but there is also indication of self-reliance with Doten's disposal of the body and his care of his wife during her fever, with the help of a friend. Mary Doten was dosed with a teaspoon of paregoric every hour and a half, and remained in bed, only sitting up on the tenth day and walking from the chair to the bed on the twelfth. The doctor charged fifty dollars for his services, and Doten paid him in installments.[16]

Suicide was relatively common in the mining communities, and a medical situation that physicians regularly dealt with. An effective, albeit slow and excruciating, method for suicide on the mining frontier was drinking carbolic acid, a strong corrosive poison. Physicians were often called to the suicide's bedside, but could do little but wait for the inevitable. A saloonkeeper convicted of manslaughter in the Truckee Meadows made an unsuccessful suicide attempt with prussic acid.[17]

Nevada's mineral strikes have generally been made in isolated areas that offer little in the way of resources, other than precious ores. Most of life's necessities were imported to the mining camps that sprang up on the barren hills and dusty valleys near the mineral strikes: timber, food, water, labor, and more. Especially in the early days of a camp, living conditions were harsh, often hazardous. Providing a nutritionally sound diet for residents of the mining camps was difficult and a number of diseases related to diet plagued Nevada and the West. Scurvy was common, though the connection between diet and disease was only vaguely understood. Many physicians prescribed antiscorbutic foods but thought that bad meat and lack of cleanliness could also be a factor in the disease. Miners in the California gold camps put their faith in the home remedy of burying themselves in dirt up to their neck, and one doctor hedged his bets by prescribing steam baths along with greens.[18]

The difficulties of providing for a rapid influx of population with an inadequate infrastructure resulted in a number of medical crises in late-nineteenth and early-twentieth century Nevada. Such was the situation at the early Tonopah camp in Nye County.

Gold and silver were discovered in Nye County in 1900, at a site named Tonopah by its founder, Jim Butler. Tonopah exemplified the problems common to mining sites. A railroad connection was sixty-three miles away and roads were nonexistent. Water, in an area with less than five inches of rainfall annually, was inadequate and there was no timber. The county population was less than 1200, excluding Native Americans. Despite these drawbacks, within a year Tonopah was a booming camp and other discoveries were being made in the area.[19]

A medical emergency occurred less than two years after the discovery and the town was unequipped to cope with the crisis. On January 12, 1902, Jack O'Toole, president of

the miners' union, sent the following telegram to Governor Reinhold Sadler:

> Epidemic prevailing here. Doctors unable to check it. Can you give us any medical assistance? Answer.[20]

Since December 31, 1901, many residents of the new town had been stricken with "pneumonia with complications" according to Dr. S. L. Lee, secretary of the State Board of Health, who was sent by the governor.[21] Dr. Lee determined that the epidemic was similar to those experienced in Hamilton, Eureka, and Pioche in the late 1860s and early 1870s, and Bodie in 1878-79. More than two dozen died in the Tonopah epidemic, although over fifty survived their bout with the disease. Dr. Lee reported to the governor that the pneumonia was complicated with "congestion of the liver, gastric disturbances, and weak heart." He noted that, unfortunately, only one autopsy had been done and it was impossible to obtain "more perfect knowledge of the pathology." Dr. Lee was convinced that the mortality rate was increased by the rough living conditions — the sick were housed in tents and it was difficult to properly care for them. In addition, the bad sanitary conditions and water supply aggravated the situation.

Tonopah had come close to having to do without the services of Dr. Lee, who was secretary of the State Board of Health and also on the Board of Medical Examiners. When first asked to respond to the epidemic, Dr. Lee protested that he had patients in critical condition, including his wife. In addition, the frugal Dr. Lee feared that the funds of the Board of Health were insufficient to support his trip south. When he was given a check for $100 and assured that the citizens of Tonopah would make a further contribution, Dr. Lee agreed to go. Governor Sadler answered the charge that Dr. Lee's fee, which totaled $300, was "extortionate" by reminding the Committee for Miners Union No. 121 that it was doubtful "that any first-class practicing physician could have been secured for less."[22]

Ranching and the Challenge of the Wide Open Spaces

Mining was the major attraction for many in Nevada, but supplying the needs of the emigrant trains had been motive for the first settlement. John Reese produced some of the products that he sold to the emigrant parties; and, within a few years, ranches and farms were flourishing in the Carson, Eagle, and Washoe valleys. Other business ventures and agricultural and livestock pursuits were launched in the nineteenth and twentieth centuries and resulted in small towns and ranches scattered all over the Silver State. Many of these were the result of mining discoveries: Monitor Valley in Nye County was connected to Ione and Belmont; Austin mining prompted settlement in the Reese River and Smokey valleys; and Paradise Valley developed near Unionville and Star City, among others.[23]

Elko County experienced early agricultural development, partly due to mining, but also because of its location near important transportation routes, first the overland stage and freight, then the Central Pacific Railroad.[24] Early entrepreneurs were anxious to prove the suitability of Nevada for agriculture and livestock, but ranchers and farmers had to accommodate themselves to the aridity of the Great Basin and the vagaries of climate. As John Wesley Powell had noted in his assessment of the lands of the West, "The grasses of the pasturage land are scant, and the lands are of value only in large quantities."[25] Expansive ranches then, measured in square miles rather

than acres, were formed in the hinterlands of Nevada; and a sparse population was spread out over thousands of miles of mountains, deserts, and valleys.

Large ranching operations tended to be relatively self-contained communities in the late nineteenth century:

> Ranch headquarters usually included a blacksmith shop, leather and harness shop, dairy, smokehouse, root cellar, laundry, bunkhouse, ice house, cookhouse, cook's cabin, chicken house, horse barn, milk cow barns, buggy house, sheds, [and] corrals . . . [26]

Like mining, ranching was rough work, and cowboys were exposed to the hazards of the environment, working with heavy equipment, and recalcitrant livestock. Accidents and illness were common, and ranch dwellers generally fended for themselves, leaving only the most serious illness to a doctor's care.

Sarah Olds wrote of her experiences homesteading north of Reno in the early twentieth century. One incident that she vividly remembered was the difficulty in getting one of her daughters, feverish from an infected shoulder, to the doctor. Home remedies had not worked, and after three days the child was getting worse. Mrs. Olds called the decision to go into town to the doctor "the hardest and most momentous" she had ever made. Her husband was also ill, and she had to leave him behind with the other children. It took her several hours to catch the horse and hitch up the wagon, and fifteen hours of driving to reach the doctor in Reno; she and the horse both fell asleep for several hours on the road. Immediately after the child was seen by the doctor, Mrs. Olds hitched the horse up again and drove back to the homestead.[27]

The northeastern section of Nevada is often referred to as the "empty quarter," a reference to its sparse population scattered throughout a large expanse. Mae Ellison, a native of Utah, has lived on Spanish Ranch in Elko County since 1932. The ranch is isolated, located about sixty miles from Elko. Mrs. Ellison recalls emergency care in the 1940s for a Mexican ranch hand who had fallen out of the barn and was bleeding profusely: she put flour in the wound to stop the bleeding until he could be transported to Elko and stitched. Most care, however, was handled by Mrs. Ellison or other hands. A physician provided an assortment of medication, and Mrs. Ellison contacted him by phone for directions for use.

Marie Jane Paris lived on a ranch about eighty miles from Ely and was frequently snowbound. In the late 1940s and 1950s when she was having her children, Mrs. Paris would go into town about two weeks before her due date to await birth. In 1952, when she and her husband had started into town to wait for a baby, they were bogged down five miles from the ranch in heavy snow and blizzard conditions. Mr. Paris walked back to the ranch for a bulldozer to dig the car out, a trip that took several hours. On the way back visibility was so poor that he had trouble keeping to the road. He periodically scraped with the bulldozer down to the gravel roadbed to check his location. When he got back to the car it was completely buried, and he found it only when he rammed into it. They made it back to the ranch house and were snowed in for another week until the county cleared the roads and they could get into town, where the baby was born three days later.

In the 1940s and 1950s many of the ranches did not have telephone service, and they relied on radio telephones for communication, talking to physicians for routine and emergency medical instruction.

Women who lived in isolated situations were always careful and tried to avoid accidents, because they were cognizant of the fact that medical help was a long way away.[28]

People who lived in isolated rural areas adjusted to the problems caused by their solitude, as did physicians. However, those who practiced in relatively uninhabited areas of Nevada found medical care complicated by the distance and the remoteness. Dr. Thomas Hood was a surgeon in Elko, following in the footsteps of his general practitioner father, Dr. A. J. Hood, who came to Nevada in 1902. The vast expanse of Nevada was one of the impressions that the elder Dr. Hood retained from the train trip from his home in Michigan to join his brother in medical practice in Elko. The train stopped frequently across Utah and Nevada. Dr. Hood had been sitting in the chair car next to another passenger who was sleeping, and as his son remembers the story:

> The train came up and ground to a halt and he was going to get out. His seat mate woke up and pulled his blind up. He looked out at the station there and said, "D E E T H. Death! and it looks like it!" And he slammed the shade back down.[29]

Dr. Hood was undeterred by his fellow traveler's commentary on Nevada; he stayed in Elko, and practiced medicine there for more than fifty years. Tom Hood recalled one incident in his father's career when he made a "house call":

> There had been an accident on the railroad at Silver Zone, this side of Wendover. One engine was pulling a freight train up this grade and the other was pushing it. Something went wrong and that thing blew up. Blew up right into a caboose and flattened things out, injured all these men and killed several of them. I can remember that phone call: my dad getting up, answering the phone, and getting dressed up in a suit and coat. He went down here to the station to be taken up on the train to treat them up there at Wendover. It was eighty or ninety miles up there, you know.[30]

Dr. Hood became the Southern Pacific District Surgeon when he first came to Nevada in 1903, and Western Pacific physician in 1908. In this position Dr. Hood could use the railroad to get to isolated areas quickly — he would stand along the tracks to flag down passing trains. This practice was discontinued in 1921 when a train stopped by Dr. Hood, already behind schedule, was held up long enough to miss a connection in San Francisco and a freighter to China. It was an expensive delay, costing the insurance company $10,000 in claims.[31]

The Wendover explosion wasn't the only train accident that A. J. Hood was called out for. In 1939 there was a major wreck near Carlin when the *City of San Francisco* derailed. The train, traveling at sixty miles per hour, left the track and tore out a bridge before plummeting thirty feet into Palisade canyon. It was the first major disaster of the innovative, lightweight streamliner; twenty-four people died and sixty-nine were injured.[32] Palisade canyon was difficult to reach by car, and the Elko doctors were rushed to the crash site in a caboose that transported patients back to the hospital for emergency care. It taxed the medical facilities of the small community, and the Southern Pacific brought doctors in from Ogden. One surgeon who was visiting in Beowawe also pitched in.[33] The wreck was headline news in the Elko papers for days

after the mishap; the train was determined to be "Maliciously wrecked," by one of the rails having been out of position by about five inches.[34]

Elko is also on an interstate highway, and that affected the type of medicine that was practiced. As a surgeon, Dr. Hood remembered that automobile accidents on Highway 40 resulted in some dreadful injuries:

> It was a two-lane highway and real dangerous at those times. I can remember in the 1950s when there would be more people injured in Elko county than in any other county in the state . . . We were on our way up to Wells, and on the way we came across this accident. Eight people were killed, I think it was, and a number injured — the worst highway accident I had seen.[35]

Dr. Leslie Moren, who practiced in Elko for more than fifty years, recalled the difficulty of getting to isolated ranches and one memorable plane ride in particular:

> They had to fly me out to Ruby Valley in a plane equipped with skis, but we couldn't get off the ground after I'd seen the patient. My butt was too heavy, so the pilot kicked me out. He didn't want to go over the hill after dark, and I went back to the ranch house and waited until the snow plow came through. It took me into Wells, and I took the bus home from Wells.[36]

As a railroad center and the only town of any size in that section of Nevada, Elko was a natural site for hobo jungles, which were located down by the river near the Western Pacific Railroad shops. Dr. Hood remembers the hobos who were down and out during the Depression and one railroad superintendent who told him, "Every morning I would go out and get a dollar's worth of dimes, and by noon they'd be all used up — a dime here and a dime there."[37]

The hobos didn't disappear with the return of prosperity. They were still there in the 1950s when Dr. Hood had his own practice:

> One day we had this one old hobo who had appendicitis. Dr. Secor was up there giving ether, and he was putting ether on the floor. I said, "What's the matter? What's going on?" He said, "Those lice are dropping off and they're getting on the floor." He was pouring ether on the floor, on the lice, and they were stone dead, yes.[38]

Dr. Quincy Fortier came to Nevada in 1945, to enter general practice in Pioche, where he took over from Dr. Jay Hastings. It was an isolated area and medical facilities were limited. There was a small hospital in town that, in a pinch, could provide beds for seven patients. The practice was varied — "Everything under the sun, from brain fungus to toe nails."

The area was relatively isolated, dependent on Las Vegas or Salt Lake City for more extensive facilities; but patients from outlying areas traveled to Pioche when bad weather limited access to the larger towns. The outlying area was extensive:

> Practice actually extended from southern Utah; after I built my big hospital, why, we had an awful lot of referrals from southern Utah. People would bring us students or a child

> that was ill or had to have surgery, and they would leave them and tell you to call them up when they were ready to go home. We'd have them as house guests as well as patients during that period.[39]

Physicians traveled long distances to get to the patients. Nevada's speed limit in those days was whatever was safe and reasonable for road conditions, and Dr. Fortier took advantage of that latitude to travel the wide open spaces: "We had these big Chryslers, Chrysler New Yorkers, and they could go one hundred, one hundred and five miles an hour."[40]

Dr. Fortier, and Dr. Hastings before him, tried to transport patients to their hospital facility when possible. Dr. Hastings had converted a Chevrolet sedan into an ambulance, and Dr. Fortier used it when he first took over the practice:

> He had it fixed so that you could roll the patients in from the back. The head would be up toward the back of the seat of the driver. It worked very well, except when you had people who were really heavy, why, then you had to be careful. They had to hold their breath as you pushed them through underneath the cowling.[41]

Small Towns

The wide open spaces of Nevada are dotted with small towns — communities that service mines, farms, the railroad, the military, and, in the case of Carson City, the government. The towns fluctuate, prospering and growing when their raison d'être prospers and grows, and contracting or disappearing altogether when industry times are bad. Facilities available to small town dwellers depend upon size and location of the community. Some are close to larger urban centers where residents can avail themselves of services. Other towns are like the ranches, isolated outposts far from the conveniences that larger towns take for granted.

When Dr. Richard Petty came to Carson City in 1941, it was a small town with about 2500 residents.[42] He was in practice with Dr. Fred Anderson until Anderson left for military service. There was one other physician in town, Dr. James Thom, and Dr. Ernest Hand was in Gardnerville. The three physicians served the Eagle Valley-Carson Valley area. There was no hospital in Carson City when he first came, so Dr. Petty was on staff at Saint Mary's and Washoe County Hospital in Reno. Working in a solo practice in a small town meant long hours, because the physician was on call all the time.

Dr. Petty left Carson for a few years and joined the navy, but came back after he was discharged. As he remembers his routine after the war, he began the day with a trip to Reno to visit his patients there in the hospital. He would come back through Virginia City, Silver City, and Gold Hill, to make house calls there, then be in the office from 1:00 until 6:00 p.m. There were several maternity homes in the area: Mrs. Pitts had one in Gardnerville, and Mrs. Noonan and Mrs. Litton each had a facility in Carson City. Home deliveries were less common after the war, and Dr. Petty delivered most of his patients in Reno. There was usually plenty of time, but he did miscalculate with one woman's fourth child:

> I checked her and I felt we could make it to Reno. But as we got out opposite Steamboats Springs, I said to her husband, "I think I'm going to have to get in the back seat and

> deliver this baby," because she said she thought it was coming. He got in to drive but the shift on the car was unfamiliar — he put it in reverse, stepped on the gas, and we backed down in the ditch! At any rate, we got out of it all right, but I delivered the baby in the back seat of the car while he was driving.[43]

When a hospital was built in Carson City in 1949, it made practice there more convenient for both patient and doctor.

Modern transportation developments have eliminated one aspect of the isolation that made medical practice particularly challenging for small town doctors. Patients can often be quickly transported by helicopter or fixed-wing aircraft to larger cities, usually Reno, Las Vegas, or Salt Lake City. In some cases, isolated small towns have developed medical facilities. The other side of the problem is that medical facilities have ceased to exist when towns decline.

Dr. Norm Christensen has practiced in Ely for the last three decades, and has seen the ups and downs of the town, and the expansion of medical facilities. Medical care for much of White Pine county's population was provided by Kennecott Copper in the decades when the company was the area's major employer. The company supported a hospital and physicians for company employees, Steptoe Valley Hospital in East Ely, and emergency hospitals in Ruth and McGill.[44] When Dr. Noah Smernoff arrived in McGill in 1929, it was a prosperous town of 7000, and he was impressed with the quality of the medical care.[45]

Copper mining, however, declined in White Pine county, and Kennecott shut down operations at Ruth in 1978 and closed the reduction plant at McGill in 1983. The copper company had cut back on medical services by 1961, and private medical facilities stepped into the breech. A medical clinic was chartered in 1961, and a hospital completed in 1969.

The licensing of physician's assistants, which began in Nevada in 1973, was aimed at extending medical care in rural communities. Although the majority of P.A.'s are working in urban areas, they have often filled a need in isolated areas.[46]

Urban Spaces

Nevada's mining towns were booming, though generally ephemeral, population centers. Mining, however, was not the only foundation for communities, and in the twentieth century, towns based on transportation and tourism flourished. The vast expanse of Nevada's range and basin topography was broken by mining settlements, ranches, and small towns, but also by expanding urban and suburban spaces. The growth of Reno and Las Vegas contributed to the modernization of Nevada medicine and stimulated expansion in the medical community. The two metropolitan areas are also the locations of the majority of Nevada's health care professionals and medical facilities.

Euro-American presence in the Truckee Meadows dates from 1844, when the first emigrant group passed through the area on the way to California.[47] Most people in the meadows were temporary until the discovery of the Comstock and the rush to Washoe in 1859. The city of Reno was established on railroad land at Lake's Crossing and was named after a fallen Union general, Jesse Lee Reno, in 1868.

The town grew slowly and the Central Pacific was the major industry. Schools and

churches were built, and newspapers began publishing. The medical community also developed: a county hospital was approved in 1876, and the state insane asylum was built near town in 1882. The railroad promoted the health benefits of Reno, proclaiming the advantages of the mineral springs in the area and the value of the clear air for asthma, but the city never developed into a health care mecca like other areas of the West.[48] The residents of Reno might have been amused about the idea of Reno as a sanitorium. There were decades of problems with providing clean water and sanitation disposal for the city. The town along the Truckee was plagued with outbreaks of summer fevers.[49]

Two Reno druggists, Pinniger and Queen, made a mark in medicine in 1879 when they created Syrup of Figs, a laxative that was advertised and sold throughout the West. The company stock was primarily owned by locals and was profitable. The enterprise branched out with franchises in Europe, South America, and Hawaii.[50]

The physicians who came to Reno and the hospitals that were built in the city provided much of the medical care for the smaller towns and ranches that made up its hinterland, particularly for more serious cases. Washoe County Hospital had competition from St. Mary's Hospital by 1908. By 1917, the Crittenden Home, Mount Rose Hospital, and St. George Hospital also provided medical services.

While mining towns boomed and busted, Reno grew slowly and steadily, depending on transportation, divorce, gambling, and tourism for its economy. Power and population did not shift south until the 1950s; but by 1960, Las Vegas was the larger city. The southern city that would eventually dominate in the state, however, started as a small dusty town in the desert.

Non-native settlement in the Las Vegas Valley dates from a Mormon mission established in 1855. The modern city of Las Vegas, however, was created in 1905, when the San Pedro, Los Angeles, and Salt Lake Railroad was completed. It remained a dusty little desert town until it boomed in the 1930s with the public works largesse of Roosevelt's New Deal and the construction of a dam on the Colorado River. The government contract for the dam, at nearly $50 million, was the single largest federal contract up to that time.[51] The legalization of gambling in 1931 provided the basis for a resort and tourist economy that would eventually create a major metropolitan area in the Las Vegas Valley. Las Vegas was slower to embrace a gambling-based

economy than Reno; but ultimately the town would overshadow cities in the northern part of the state, demographically, politically, and economically.[52]

In 1930 the population of Las Vegas was about 5100 — a fairly small town compared to Reno's 18,000 residents.[53] In many small towns, medical facilities occupied whatever space was available, and this was true with Las Vegas. The first hospital in Las Vegas had come with the railroad, a four-bed tent.[54] Until Las Vegas Hospital was built in 1931, Dr. Roy Martin worked out of a hospital he established in the former Palace Hotel. Working in the heat in the days before air conditioning was grueling, and elective surgery was not scheduled in the summer. If an emergency required surgery, it was done between 4:00 and 5:00 a.m.; some relief was provided by a primitive cooling system of fans blowing air over blocks of ice.[55]

The construction project for Hoover Dam was an important spur to growth in the Las Vegas Valley, but it also presented medical challenges. The dam site, at Black Rock

Canyon, was an arid and isolated place. The summer heat was enervating and deadly, and the steep canyons were lethal and unforgiving. The technology and massive equipment that would eventually harness the Colorado River could maim and kill the careless, the unwary, or the unlucky. Men worked hundreds of feet above the canyon floor, suspended in fragile harnesses; many died from falls.

With average daily temperatures of 119 degrees in the summer of 1931, heat prostration killed a number of men, as well as their families, in the early days of the project. Men who didn't die at the site were packed in ice and taken to Las Vegas. One physician said that men had come into the hospital with body temperatures of 112 degrees. The cause of the problem, dehydration, was not understood until researchers from Harvard studied the situation in the Nevada desert in 1932.[56]

There was also disease and illness from crowded living conditions and bad water and food. Injuries on the job were often extensive and serious. Those who became ill or who were injured at the job site had to be transported to Boulder City, a distance of more than ten miles, or another thirty miles farther to a Las Vegas hospital.

Construction of a hospital was one part of the infrastructure created to support the workers needed for the dam project. At the request of the government, Six Companies, the construction consortium that built the dam, also built a hospital. The twenty-bed unit had an orthopedic and maternity facility, both important for the dam workers and their families. Employees paid a monthly fee of $1.50, deducted from their salary, for the use of the facility.[57]

A unique complication in health care emerged from the Hoover Dam project. Because the dam straddled the border of two states, both Arizona and Nevada had responsibility for part of the project site. Arizona, however, compensated victims and their families at a higher rate than Nevada. Some injured workers struggled across the border after an accident, those with broken legs crawling. Six Companies, which paid into the insurance fund for both states, tried to minimize their liability by employing single men on the Arizona side. There were also a number of deaths from "falling pneumonia" in the first years of the project. Six Companies avoided responsibility and death benefits to the families of workers who died from disease rather than injury, hence the numbers of deaths from "falling pneumonia." The company was reprimanded after a government investigation and halted the practice.[58]

Hoover Dam was completed in 1936. Although the majority of the workers moved on, the dam itself became a tourist attraction. The electricity generated ran the air conditioners that made even summer in the desert tolerable and lighted the neon signs of the casinos. During the 1930s and 1940s Las Vegas expanded, utilizing federal money during the war and tourist dollars both before and after World War II to fuel its economy. By 1960 it was a metropolitan area of 64,000.[59]

Dr. Kenneth Turner moved to Las Vegas from Truckee in 1960. There was a need for physicians in the flourishing city. Some of the physicians there had been around for many years, and were as colorful as the reputation of Las Vegas itself. Dr. Turner was impressed by Dr. Jack Cherry, a general practitioner who had worked in Goldfield before coming to Las Vegas:

> I considered him Mr. Las Vegas.
> He always had this big diamond ring

> on his finger, he had a big cigar, he dressed really sporty, and he always had about two thousand dollars worth of hundred dollar bills in his sock. You'd be in surgery and you'd see this big bulge in his sock. [laughter]

Dr. Turner remembers Dr. Cherry telling him about problems with hospital privileges after World War II. The problem was solved when "he wangled some Quonset Huts from the army, and that was the start of Southern Nevada Memorial Hospital."[60]

Dr. Kirk Cammack also came to Las Vegas in 1960, and remembers it as an exciting place to be, with "constant turmoil — people coming and going and interesting sorts of characters from everywhere in the United States." Some of the characters were "shady" and paid their hospital bills from a roll of money in their pocket — "Some of it would even smell mildewed. [laughter] They dug it up from someplace." Discretion was an important part of the physician's role:

> A lot of them are dead now, but one of them told me, "Say, Doc, this is graveyard. If you repeat what I've told you it's the graveyard for you."[61]

Just as the small towns adapted to meet the needs of patients, so too, as a growing metropolitan area, Las Vegas was pressed to expand. The medical community was short of specialists, and doctors filled in where they could. Dr. Turner described 1960 medicine in Las Vegas as primitive, but that changed over the decade:

> A lot of doctors that came to town in the early 1960s had come to town for divorces and then stayed here . . . in about 1964 physicians started coming in . . . [and] the 1960s were an era that had really impressive growth in medicine.

Las Vegas hospitals developed programs that brought medical residents into the community, and in 1964 OB/GYN residents came from San Francisco. That continued until the University of Nevada developed its medical school in 1971 and produced its own residents. As Reno and Las Vegas expanded, the medical community developed along with the cities.

Physicians were among the first settlers to the state of Nevada, and they have been involved in community building, whether serving the mining towns, the ranches, the small rural towns, or the larger cities that emerged as the state has grown. Some physicians lived in several parts of Nevada, moving with the mining communities and eventually settling in one area. Their contribution was their experience of the state and the change they witnessed, as well as their medical knowledge. Physicians have been observers and participants in Nevada's history, and the overall history of medicine. Medicine, and the people who administer it, provides one part of the full picture of the past.

Many of the physicians who were active on the Board of Medical Examiners were an important part of the increasing sophistication of medicine in Nevada. They were the individuals who examined and licensed physicians new to the state, who disciplined those who had betrayed, deliberately and inadvertently, the tenets of the medical profession. The legislation that created the Board of Medical Examiners, as well as the alterations that modernized it, are another part of the history of the Board and the Silver State.

Notes

1. This overview of Western medicine is based on an issue of *Journal of the West* 21 (July 1982), devoted to medicine in the West.

2. James O. Breeden, "'Medicine in the West' — An Introduction," *Journal of the West* 21(July 1982): 8-10.

3. Phyllis Japp, "Pioneer Medicines: Doctors, Nostrums, and Folk Cures"; John Duffy, "Medicine in the West: An Historical Overview," *Journal of the West* 21 (July 1982): 5-13.

4. Russell R. Elliott, *History of Nevada*, 2d ed., rev. (Lincoln: University of Nebraska Press, 1987), 147.

5. For information on health on the Comstock, see Duane A. Smith, "Comstock Miseries: Medicine and Mining in the 1860s," *Nevada Historical Society Quarterly* 36 (Spring 1993).

6. Mary McNair Mathews, *Ten Years in Nevada or Life on the Pacific Coast* (Lincoln: University of Nebraska Press, 1985), 44.

7. Mathews, 55.

8. Dr. Charle Umle, "Hysteria," *Lippencott's* 483 (September 1870); *Territorial Enterprise*, 4 July 1868; 7 February 1868.

9. Smith, "Comstock Miseries," 5; Cynthia Pinto, "First Hospital on the Comstock: Saint Mary Louise," *Greasewood Tablettes* 1, no. 4 (Winter 1990-91); Silas E. Ross Papers, Special Collections, Getchell Library, University of Nevada, Reno, 4.

10. Eliot Lord cited in Elliott, *History of Nevada*, 97; Elliott, *History of Nevada*, 131.

11. *Territorial Enterprise*, 5 March 1867.

12. Marion Goldman, *Gold Diggers and Silver Miners: Prostitution and Social Life on the Comstock Lode* (Ann Arbor: The University of Michigan Press, 1981), 126.

13. Goldman, 127.

14. Nevada Legislature, *Statutes of Nevada,* 12th sess. (Carson City: State Printing Office, 1885), 1020.

15. Goldman, 130.

16. Walter Van Tilburg Clark, ed., *The Journals of Alf Doten* (Reno: University of Nevada Press, 1973), 1473.

17. John M. Townley, *Tough Little Town on the Truckee*, History of Reno Series, vol. 1 (Reno: Jamison Station Press, 1983), 59. Newspaper accounts of suicide attempts were common in the mining communities, and prostitutes were frequent casualties to despair. The reports of their deaths were often less than sympathetic, implying that it was a natural end to such a sordid existence.

18. Joseph R. Conlin, *Bacon, Beans and Galantines: Food and Foodways on the Western Mining Frontier* (Reno: University of Nevada Press, 1986), 73-74.

19. Russell R. Elliott, *Nevada's Twentieth-Century Mining Boom* (Reno: University of Nevada Press, 1966), 6-8.

20. Reinhold Sadler, governor of Nevada, *State of Nevada Message, Appendix to Journals of Senate and Assembly of the Twenty-First Session* (Carson City: State Printing Office, 1903), 7.

21. For a brief overview of Dr. Lee and his association with the Nevada State Board of Health, see Guy Louis Rocha, "Regulating Public Health in Nevada: The Pioneering Efforts of Dr. Simeon Lemuel Lee," *Nevada Historical Society Quarterly* 26 (Fall 1986): 201-209.

22. Sadler, 8.

23. Elliott, *History of Nevada*, 115, 119.

24. Elliott, *History of Nevada*, 120.

25. Quoted in James A. Young and B. Abbott Sparks, *Cattle in the Cold Desert* (Logan: Utah State University Press, 1985), 93.

26. Young and Sparks, 185.

27. Sarah E. Olds, *Twenty Miles from a Match: Homesteading in Western Nevada* (Reno: University of Nevada Press, 1978), 46-52.

28. Information on ranch women comes from a forthcoming publication, scheduled for late 1995, based on oral histories, Evelyne Stitt Pickett, *Ranchwomen in the Empty Quarter* (College Station, Tex.: Texas A & M Press).

29. Dr. Thomas Hood interview, August 1994.

30. Hood interview.

31. Edna B. Patterson, *Sagebrush Doctors* (Springville, Utah: Art City Publishing Company, 1972), 91.

32. *Elko Independent*, 18 August 1939; *Elko Daily Free Press*, 17 August 1939; Patterson, 140.

33. Owen C. Bolstad, *Leslie Moren: Fifty Years an Elko County Doctor*, Great Basin History of Medicine Series (Reno: University of Nevada Oral History Program, 1992), 36-38.

34. *Elko Daily Free Press*, 22 August 1939.

35. Hood interview.

36. Dr. Leslie Moren interview, August 1994.

37. Hood interview.

38. Hood interview.

39. Dr. Quincy Fortier interview, August 1994.

40. Fortier interview.

41. Fortier interview.

42. John L. Andriot, ed., *Population Abstract of the United States*, vol. 1 (McLean, Va.: Andriot Associates, 1983), 505.

43. Dr. Richard Petty interview, November 1994.

44. Russell R. Elliott, *Growing Up in a Company Town: A Family in the Copper Camp of McGill, Nevada* (Reno: Nevada Historical Society, 1990), 112.

45. R. T. King, *Noah Smernoff: A Life in Medicine*, Great Basin History of Medicine Series (Reno: University of Nevada Oral History Program, 1990), 34-35.

46. The legislation providing for licensed physician's assistants is discussed in Chapter Four.

47. Details on Reno's early history can be found in Townley, *Tough Little Town on the*

Truckee, and William D. Rowley, *Reno: Hub of the Washoe Country* (Woodland Hills, Calif.: Windsor Publications, 1984). See also Barbara and Myrick Land, *A Short History of Reno* (Reno: University of Nevada Press, 1995).

48. Rowley, 26.

49. Townley, 82, 158.

50. Townley, 238.

51. Joseph E. Stevens, *Hoover Dam: An American Adventure* (Norman: University of Oklahoma Press, 1988), 47.

52. Elliott, *History of Nevada*, 216, 284. For the earliest settlement of Las Vegas see Stanley W. Paher, *Las Vegas: As It Began — As It Grew* (Las Vegas: Nevada Publications, 1971); for later development see Eugene P. Moehring, *Resort City in the Sunbelt: Las Vegas, 1930-1970* (Reno: University of Nevada Press, 1989).

53. Andriot, 505.

54. Sandra C. Klimek, "A History of Hospitals: Clark County, Nevada" (Master's thesis, University of Nevada, Las Vegas, 1985).

55. Stanley Paher, *Las Vegas: As It Began — As It Grew* (Las Vegas: Nevada Publications, 1971), 145.

56. Stevens, 60.

57. Klimek, 4-5.

58. Stevens, 164; Klimek, 5.

59. Andriot, 505.

60. Interview with Dr. Kenneth Turner, August 1994.

61. Interview with Dr. Kirk Cammack, August 1994.

3

The First Half Century of the Board of Medical Examiners

As early as the seventeenth century, efforts were made to safeguard the health of citizens by exerting some control over the practice of medicine. The Massachusetts colonial law of 1649 that supervised physicians proved to be ineffective, as were other early efforts to regulate the practice of medicine in America. Concern was expressed over the damage done by ignorant practitioners, but translating anxiety about "Quacks [that] abound like locusts in Egypt" into workable control of medical practice proved to be a chimera.[1]

As colonial society expanded and matured, well qualified medical practitioners increased in number. Occasional attempts were made to organize the profession and to restrict medical practice through licensing. Seventeenth-century licensing laws in Massachusetts, New Jersey, and New York proved ineffective and legislation in the eighteenth century was not much more successful. A medical licensing bill failed to pass the South Carolina legislature in 1765, and medical regulations enacted in New York in 1760 and in New Jersey in 1772 were unpopular and difficult to enforce. Many among the colonial population were annoyed by the air of superiority affected by trained physicians, and resented their efforts to disparage their less well educated colleagues. In addition, as noted earlier, Americans utilized a wide variety of medical resources. Many viewed medical licensing as a hindrance on their freedom of choice in medical options.[2] Public resistance to restraint of medical choice surfaced repeatedly against efforts to regulate medical practice. Although medical practitioners continued their efforts to organize and restrict their field, success eluded them until after the American Revolution.

As all wars do, the revolt against Britain created a need for medical facilities for the army, and physicians from different colonies came together in the military. A prominent colonial physician, Dr. John Morgan, recommended some sort of qualifying examinations, a practice which was instituted. This prompted post-Revolutionary calls for examination of civilian doctors.

The nation building that followed the American Revolution resulted in a search for aspects of culture that could be deemed uniquely American, accomplishments that would vindicate rebellion. An important part of American culture that was glorified was achievement in science, and medicine was part of that science. Richard Shryock described pride in American medicine as "bordering on euphoria" by the early nineteenth century, though he noted such pride was about a century early. The identification of medical progress with national progress, if premature, provided support for medical reform. By the 1830s there were medical societies in most states, and prospects for licensing and testing requirements were encouraging.[3]

Early organization for licensing and registration, however, was weak. The democratic emphasis and anti-elitism of the Jacksonian period worked against regular physicians' efforts to consolidate control of the medical field. The popularity of the irregular sects, such as the Thomsonians and other groups discussed in Chapter Two, that stressed simplicity and self-reliance in medical care, contrasted sharply with the impression of authority that was associated with regular medicine. The proliferation of medical schools turning out poorly trained, often untrained, doctors contributed to the decline of respect for the profession. By the late 1830s licensing laws had been repealed in most states.[4]

Raising and protecting the status of the medical field was a difficult task. The American Medical Association was formed in 1847 as an attempt to consolidate and control regular medical practice, but it was not until the 1870s that stronger state medical societies emerged and began to reform medical education.[5] State licensing and examination also re-emerged, though gradually and not without conflict. Paul Starr's study of the medical profession emphasizes changes between the Jacksonian period and the Progressive period that resulted in both "the advance of science and the decline of confidence in common sense . . . [that] helped restore a belief in the legitimate complexity of medicine."[6]

Starr sees evidence of the decline of confidence in common sense in the state's victory in a court case that was crucial to the advancement of medical control. The authority for state medical examining boards to deny licensure to individuals deemed incompetent came from an 1888 Supreme Court decision, *Dent v. West Virginia*. In this case an eclectic physician in West Virginia was convicted and fined for failing to comply with state law regarding licensing. The West Virginia Board of Health did not accept Frank Dent's medical education from a Cincinnati eclectic medical college. The opinion of the court was unanimous. In the words of one justice, no individual had "the right to practice medicine without having the necessary qualifications of learning and skill."[7] The state had a duty to guarantee that individuals were skillful and to protect society: "Few professions require more careful preparation . . . than that of medicine . . . [and] comparatively few can judge the qualifications of learning and skill" that their doctor possesses. Another case ten years later, *Hawker v. New York* (1898), addressed the issue of character as significant for a physician, finding it as important as knowledge.[8]

In the middle decades of the nineteenth century there had been important changes in attitudes toward licensing and regulation. Independent artisans, businessmen, and professionals found competition by large corporations increasingly difficult to counter. These groups supported legislation that bolstered and protected their precarious

position. The convention of grandfathering in individuals who had been practicing medicine, or whatever field was being regulated, undercut resistance by those who could not meet new criteria.[9]

Thus fortified, medical regulation could move forward. The status of American physicians was on the rise, though not until the twentieth century could the practice of medicine truly be considered a socially and financially rewarding career. It was against this background that Nevada physicians and legislators began to take steps to regulate and improve the quality of medical practice.

19th Century Medical Legislation in Nevada, 1875-1899

In the first decade of statehood, Nevada law made no provision for the regulation of medical practice. There were numerous physicians practicing sundry types of medicine in the state. Some of them were drawn to the possibilities for quick wealth in the mines as well as a chance to establish a thriving practice in the rough communities where disease and injury were a constant. Virtually anyone could set up shop as a doctor in the territorial period and the earliest days of statehood in Nevada. The first attempt to restrict medical practice was an 1875 law aimed at preventing "the practice of medicine and surgery by unqualified persons."

This statute made it illegal for individuals to practice medicine or surgery unless they had received a medical education and a diploma from a regularly chartered school, one that had a "bona fide existence when said diploma was granted." Physicians were required to file a copy of the diploma and show the original in the county were they intended to practice.

Although practicing medicine without registering was only a misdemeanor, filing a fraudulent diploma was a felony. As an incentive to vigilant law enforcement, the officer who arrested an unregistered physician was entitled to half the fine collected. Physicians who had been practicing in the state for ten years were grandfathered in; and it was also legal for any person to practice medicine in an emergency in a community where no physician resided.[10]

Further effort to protect the public was made two years later. One 1877 statute enacted by the legislature outlawed unrestricted distribution of opium, limiting its sale to druggists and apothecaries, who could dispense only with the prescription of "legally practicing physicians." Opium use was widespread in nineteenth century America and its abuse was considered a grave social evil. With this legislation, opium dens, "places of resort for smoking or otherwise using that drug," were outlawed.[11]

The eighth legislative session attempted to curb another social evil by prohibiting "certain advertisements tending to promote licentiousness and crime."[12] The specific licentious behavior they were concerned about was birth control and abortion. Nevada legislators were not unique in their efforts to regulate reproduction. There was increasing anxiety among some groups in the United States about the falling birth rate, a concern prompted in part by the rising tides of immigration, and fears that "'the ignorant, the low-lived and the alien'" were outpacing the true Americans — white, native-born citizens. In 1873, the New York Society for the Suppression of Vice, led by Anthony Comstock and supported by a loose coalition of physicians and nativists, prompted Congress to pass an act making it illegal to disseminate birth control and abortion information, or to

sell or advertise products for birth control or abortion.[13] Dr. Moses Walker, in his 1944 history of Nevada medicine, attributed this legislation to changed conditions and ideas in Nevada, where "frontier individualism and philosophies [were] giving way to technological and social advance . . . a determination to keep pace with the folks back home."[14]

Legislation dealing with medicine in the early decades of Nevada statehood was focused on broader issues of public health rather than regulation of medical practitioners. Appropriation was made in 1881 for the construction of a state hospital for the insane in Reno. Dr. Walker applauded the action, noting that "a few were unable to withstand the vicissitudes" of frontier life, but regretted the political situation that made the job of superintendent of the mental hospital a "political plum."[15]

In 1889, responsibility for a county board of health was assigned to county commissioners; but by 1893, Nevada had enacted a statute creating a State Board of Health. Three physicians were appointed to the new board. They held their first meeting to organize in March, 1893. Actually, that was their only full meeting in the first two years of the board's operation. Dr. S. L. Lee explained in his report to the governor:

> The fund appropriated to meet all contingencies during the years of 1893-94 was but one thousand ($1,000) dollars, and inasmuch as it would cost about $65 to call the Board together, we deemed it the part of wisdom to await the appearance of an epidemic or contagion before calling a meeting that would so seriously deplete the small fund at our disposal.

The board's only action in its first year was to investigate "an epidemic of continued malignant fever" in Washoe City. They found that carcasses from a slaughter house were polluting the water, and recommended to Washoe County authorities that the nuisance be abated. The frugal Dr. Lee concluded his report with the announcement that only $95.50 of the $1000 had been spent in 1894.[16]

Creating the Board of Medical Examiners

More formal regulation of the practice of medicine in Nevada began with the creation of the State Board of Medical Examiners in 1899.[17] The Nevada legislation was part of gradual change in medical licensing and regulation that was occurring nationally. A survey published in the *Bulletin of the American Academy of Medicine* in 1897 classified medical regulation and rated the states according to their requirements for legal medical practice.[18] Nevada's requirements for recording a copy of a medical school diploma with the country recorder were determined to belong in a category "where the law imposes practically no restriction."

Nevada was not unique in that standing. Of ten other western states and territories in the continental United States that were rated in the survey, four (Montana, Oregon, Utah, and Washington) required exams. Colorado State and New Mexico Territory recognized some diplomas and examined some applicants. Only California required a diploma. Arizona Territory, Idaho, and Wyoming were placed with Nevada in the "practically no restriction" group.[19] Nevada, then, was not isolated in its lack of effective medical oversight, but neither was it on the forefront of reform.

In 1899, the Nevada legislature took steps to remedy the lack of medical oversight in the state. On February 2, Assemblyman McGowan of Ormsby County introduced Assembly Bill No. 29, "An Act to regulate the practice of medicine and surgery in the State of Nevada."[20] Part of that regulation was the establishment of a Board of Medical Examiners as the examining and regulatory body for physicians. The Board was given the authority to issue certificates to physicians who had been practicing in Nevada for the preceding five years or those who presented diplomas from "reputable" medical schools or colleges; the Board determined whether a college was reputable. Board members were also directed to conduct "thorough and searching" examinations.[21]

The creation of the Board of Medical Examiners was not the most important news for many observers of the nineteenth legislative session. Far more exciting, and rancorous, was the senate race between Francis Newlands and William Stewart. For those who did not take their politics so seriously, Speaker pro Tem Coryell's plan to introduce a bill "preventing the wearing of high or large hats at places of amusement for ladies" could be debated.[22] On the international scene, the progress of the Spanish-American War and the fighting in Manila was of greater interest than the examination and licensing of physicians.

The proposed law regarding physicians, however, was scrutinized and found lacking by the editor of the *Reno Evening Gazette*, who expressed grave concern over the proposed medical board and the impact of the legislation on the practice of medicine in Nevada. When the Assembly bill was first introduced the *Gazette* charged that it was a thinly veiled effort to open the medical profession in Nevada to "non-graduate quacks," but didn't explain the accusation. The editor noted that the existing law, requiring that diplomas from a "regularly chartered and actually existing" Medical College be registered with a county recorder, was not ideal. There was no provision for checking the standing of the medical schools or the legitimacy of the diplomas. To the *Gazette's* knowledge, however, there had been only two cases of fraud within the last two years.

The editorial conceded that there existed a number of self-styled physicians who simply presented themselves as M.D.'s, and the editor labeled such practice deplorable. Under Assembly Bill No. 29, however, individuals who had practiced medicine in the state for eight years would be recognized as physicians. The Reno newspaper feared that this would provide:

> . . . legal recognition for irregular practitioners, quacks, abortionists, drug and nostrum vendors and all others who in the past professed publically [sic] to be physicians, and prescribed for the sick or who appended to their names the letters, "M.D.," and by lawful process establishes them as the equals of bona fide doctors of medicine.[23]

Acknowledging the abuses of public trust and the inadequacies of present law, the *Gazette* still preferred the law as it existed, or no law, over the proposed change. The editor was of the opinion that under current law the public assumed the responsibility for determining the quality of a medical practitioner rather than being misled by the Board of Medical Examiners into thinking that licensed physicians were actually qualified.

There is a certain irony in the fact that directly under the editorial in which the *Gazette* expressed concern over the welfare of people who were vulnerable to "drug and

nostrum vendors," there were advertisements for three such nostrums. According to one ad, "Laxative Bromo Quinine Tablets" would cure a cold in one day. Another warned that "La Grippe is again epidemic," but promised that a prudent individual could avoid the malady with "One Minute Cough Cure." It would cure the affliction pleasantly and quickly, and "'No one will be disappointed in using One Minute Cough Cure for La Grippe.'" And those suffering the distress of "Eczema!" could be helped, even "the most obstinate case," with "S.S.S. For the Blood." H. T. Shore of St. Louis, Missouri, provided a testimonial: Only a dozen bottles of S.S.S. had cured her daughter of the "dreadful disease." It is possible that there is no irony in the location of the advertisements for the drugs — the *Gazette* had advocated public responsibility for medical choices, and the proffering of alternative choices for illness might have been deliberate.[24]

The legislation that the *Gazette* opposed mandated that the Board of Medical Examiners be appointed by the governor and consist of "five practicing physicians" who had been engaged in practice for five years immediately preceding their appointment. Cognizant of the diversity of medical practice, the legislature required that three of the Board members "be appointed from the schools of medicine known as the 'regular' physicians," one from the "school known as 'Homeopathic,'" and the fifth member from the "'Eclectic'" school. The inclusion of sectarian representatives on licensing boards was a common practice, and an important factor in the success of allopathic medicine. The sects were generally absorbed into regular medicine rather than pushed out of business. The AMA recognized the inevitability of coalitions formed by varying medical beliefs in 1903 when it softened its prohibition of contact with irregulars as part of the code of ethics.[25]

The *Gazette* was, predictably, unhappy with the medical legislation passed. When the Board of Medical Examiners met in Carson City, the newspaper commented that the new law "was needed about as much as a wagon needs five wheels," concluding that "from a medical standpoint Nevada has retrograded twenty years."[26]

It doesn't appear that the *Gazette's* dire predictions came true. The first few years that the Board of Medical Examiners was in existence were not particularly lively according to the biennial report that the secretary of the Board, Dr. S. L. Lee, submitted to the governor. The Board organized at its first meeting by electing officers and assigning examination subjects to its members. Unfortunately, in the first two years only one individual applied to be examined, and he did not finish his examination (See Appendix 2 for questions on the first exam administered).

The Board appealed to all practicing physicians to register; but according to Dr. Lee, since the law was not compulsory, many physicians "declined" to register. Forty-two physicians did, however, pay the twenty-five dollar fee and register with the Board. Based on the diplomas presented, a list of twenty-nine recognized medical schools was compiled. Two schools, the Independent Medical College of Chicago and the Electro-Therapeutic College of Indianapolis, were listed as unrecognized medical schools. Dr. Lee's parsimony, evident in his work with the Public Health Board, was also apparent in his stewardship of the Board of Medical Examiners; Dr. Lee collected $365 and spent $351.25.[27]

The Board was little busier in its second biennium. In 1902, Dr. Lee reported that fifty-

seven physicians had been registered and no one had applied to be examined. Possibly in an attempt to flesh out the rather scanty news of the Board's activities, Dr. Lee included the text of the legislation that had created the Board four years earlier.[28] There were no more biennial reports from the Board in the early years.

Early Legislation and Issues

In contrast to its laissez-faire approach to medical practice regulation in the nineteenth-century, the Nevada legislature passed a number of laws directed at public health and the medical establishment in the twentieth century. Legislation increased the scope and complexity of state involvement in medical practice, reflecting national trends of governmental oversight of public welfare and health.

After the legislation mandating the Board of Medical Examiners, the next effort to regulate medical practice was made in 1905. That year the legislature specified what constituted the practice of medicine, both good and bad.[29]

Physician certification could be obtained in a number of ways. Under this law there was a proviso for reciprocity. As long as the laws of another state required as much for licensing as those in Nevada, and as long as that state recognized Nevada licensing, then the applicant could present a certificate from another state as proof of his competency and could practice in Nevada.

A physician could also be registered by presenting a medical school diploma, although there were conditions attached. The diploma had to be from a regularly chartered medical school with requirements equal to those prescribed by the Association of American Medical Colleges. In addition to the diploma, an affidavit attesting to the number and duration of terms attended at the college was required. The applicant also needed local support in the form of affidavits from two resident "freeholders" in the country where he or she intended to practice, confirming that the applicant was "the identical person named in the diploma" and was "of good moral standing and reputable." The third option for certification was to present a diploma and pass a "fair and impartial" examination in specified subjects.

The Board was given the power to refuse or revoke a certificate for "unprofessional conduct." Action that constituted unprofessional conduct was specified in the statute:

> First — The procuring or aiding or abetting in procuring a criminal abortion.
>
> Second — The obtaining of any fee on the assurance that a manifestly incurable disease can be permanently cured.
>
> Third — The willfully betraying a professional secret.
>
> Fourth — All advertising of medical business in which grossly improbably statements are made.
>
> Fifth — All advertising of any medicines, or of any means, whereby the monthly periods of women can be regulated, or the menses reestablished if suppressed.
>
> Sixth — Conviction of any offense involving moral turpitude.
>
> Seventh — Habitual intemperance.

Activity that constituted the practice of medicine was also specified. Individuals who used the words "Dr., Doctor, Professor, M.D., or Healer" were considered physicians and

subject to the jurisdiction of this legislation. United States Army and Navy surgeons or those called into the state for a consultation were specifically excluded. As in earlier law, the practice of medicine without a certificate was a misdemeanor, but falsification of a diploma was a felony.

Those practicing physicians who had complied with the 1899 act would be registered free. Those who had been in practice before 1899 but who had not registered were required to submit the diploma and pay a five dollar fee, rather than the twenty-five dollar fee for new registrants.

The Medical Practice Act was fine-tuned in 1907 and 1911, although there was no substantive change. In 1907 the language that had earlier grandfathered in practitioners was removed. Accommodation to alternative medical beliefs continued when the 1911 change made provision for practitioners of the "system of what is generally known and recognized as the drugless system." Acknowledgement of alternative medical treatment, however, did not necessarily signify acceptance of physicians or beliefs outside the medical mainstream. Affirmation of allopathic medicine's preeminence in Nevada by the 1920s is indicated in the eventual defeat of a homeopathic physician's bid for a position on the Board of Medical Examiners.

Allopaths Prevail

In 1919 Governor Boyle received a letter from Dr. A. R. DaCosta, a Reno homeopathic physician. Dr. DaCosta informed the governor that he had received an inquiry from the American Institute of Homeopathy in Chicago about Nevada's requirements for homeopathic representation on the Board of Medical Examiners and whether there was a homeopathic member on the Board. After checking with S. L. Lee, Dr. DaCosta had learned that when the homeopathic Dr. Grigsby had left the Board, there had been no homeopathic applicant, and a regular physician was appointed in his place. Dr. DaCosta then informed the governor of his reply to the institute, but reassured him regarding motive:

> I have advised them of this and expect that they will clamor for a representative on the Board.
>
> I am not seeking any position, but should you deem it necessary to have a Homeopath on the Board as law provides and desire me to do so I would serve.

Dr. DaCosta advised Governor Boyle of his qualifications and connections in Chicago, and assured him that the institute would "be pleased at my going on the Board. However this is as you desire."[30]

A week later, Governor Boyle received a letter from the American Institute of Homeopathy, whose "attention [had] been called to the fact" that the Board was not in compliance with the law. The letter informed the governor that in such cases in other states the authority of the board had been questioned in court, and the courts had determined that a board's authority was voided when the law was not carried out according to its original intention.

Governor Boyle informed the institute that he would look into the matter after the holidays. When the institute prodded him again in January 1920, he indicated his intention to take up the matter at the next Board meeting. Dr. DaCosta was still pursuing the matter in April 1921, asking for a resolution, "as the American Institute of

Homeopathy are asking me to report to them regarding this matter."

A letter in May from the governor to Dr. W. M. Edwards, a member of the Board from Mason, indicated that Dr. Edwards had offered to resign. The governor found himself with "no option but to carry out the mandate of the statute," and indicated that he found a change in personnel on the Board "distasteful." If Dr. Edwards was still willing, however, the governor would accept his "more than generous offer." Dr. Edwards resigned three days later and Boyle appointed J. A. Lewis, who he "was pleased to find" was a homeopath, to the Board. The governor admitted to Dr. Edwards his fear that "this action will not be any too enthusiastically received by the homeopathic organization which has created most of the trouble on this board."

In late 1922, after Lewis resigned from the Board to leave the state, Governor Boyle appointed A. R. DaCosta to finish Dr. Lewis's term. Unlike other correspondence, the letter of appointment was signed by the governor's secretary. Five months later, Dr. DaCosta was writing to then Governor Scrugham, this time inquiring about an article in the *Journal* regarding appointments to the Board and whether he had been dropped from the Board. Dr. DaCosta was rather curtly reminded that his appointment to the Board had been for an unexpired term, and his term of service for the Board had ended. He was also informed that the legislature had changed the requirement for a homeopathic member,[31] and a Dr. Robinson would take his place. Dr. DaCosta, who had waged a four-year campaign to obtain a position on the Board, served for less than two months and his name was not part of the list of Governor Boyle's appointments to the Board. The physician, however, was nothing if not persistent. In 1936 he wrote to Governor Kirman requesting an appointment to the Board of Medical Examiners.[32] There is no record of a second appointment.

The 1923 change in the law eliminating representation from diverse medical schools of practice on the Board of Medical Examiners was essentially a housekeeping matter. By then, nationally and in Nevada, allopathic physicians had long embodied mainstream medicine in the United States. The sectarians were absorbed into regular medicine, and distinctive schools and medical societies disappeared, a process that was complete by the 1930s.[33] Homeopathic medicine was relegated to a minor role nationally, and it remained on the medical sidelines in Nevada until it reemerged in the early 1980s as a viable alternative medical practice.

Fine-tuning Early Legislation

Board members actively worked to improve medical legislation in the state. In a 1928 letter to the Board Secretary-Treasurer, Board President Earle L. Creveling mentioned: "I received the Red Book from the American Medical Association and have read over the laws of several of the states and find much that could improve our medical practice act."[34] And changes were implemented.

In 1925 practicing medicine without a license or "assuming to act" as a Board member was elevated from a misdemeanor to a gross misdemeanor. A 1929 amendment altered the wording of the medical school diploma requirement from one that was "legally chartered" to one "recognized as reputable" by the Board, a change that expanded the power of the Board. In addition, the section providing that the applicant "designate in what school of medicine he desires to practice" was eliminated, a further acknowledgement of allopathic dominance in medicine. The

specifications for unprofessional conduct were altered and an annual tax on the license, to be regulated by the Board, was imposed.[35] The tax was requested by the Board to augment their meager funds. As the Board secretary-treasurer informed the secretary of the Washoe County Medical Society: "That is the only thing to do in order to get a Treasury of sufficient size for an employee to investigate, and if need be a lawyer to protect the interest of our proffession [sic]."[36]

Changes in the Medical Practice Act in the 1930s further expanded the scope of the Board's activities and formalized the process for filing charges against physicians and their rights for appeal. A 1931 change limited medical licenses to citizens of the United States or to those who had declared an intent to become citizens.[37]

Accommodating World War II

As with the rest of the nation, indeed the world, the Second World War had a tremendous impact on Nevada. The 1940s were a decade of growth and expansion in the state as military and federal expenditures replaced earlier mining strikes as the impetus for boom times.

There were many wartime shortages, among them a dearth of medical personnel as the nation tried to distribute physicians to provide for medical care on both the home front and the military front. The Nevada legislature in 1943 enacted temporary legislation to deal with the crisis, acknowledging:

> An emergency now exists in certain sections of the State of Nevada relative to the availability of medical and surgical services, due to the entry of Nevada doctors into the armed forces of the United States . . . . [38]

There were also problems with transportation for medical services in Nevada's vast expanse because of wartime gasoline rationing. To cope with the scarcity, the Board of Medical Examiners was given the power to issue temporary licenses "at its discretion" for medical practice.

Regular fees were charged, but this provision bypassed the usual licensing procedure, speeding up the process for granting physicians the right to practice in the state. The temporary licenses were scheduled to expire in 1945, but as the conflict dragged on, the legislature extended the termination date to 1947.

Nellis Air Force Base in southern Nevada and Stead Air Force Base in the north were established in 1941 and 1942, respectively, as well as other military installations in the state.[39] Large numbers of military personnel came and went through the state during the wartime years, among them Nevada men and women who were part of the wartime military effort. Several physicians who were serving on the Board of Medical Examiners in the war years left the state for active duty; many of those who were later appointed were part of the conflict.

In June of 1941, Dr. Richard Petty had finished an internship at Southern Pacific General Hospital and was on the train back to Illinois when he received a telegram at Colfax, California. Dr. Fred Anderson of Carson City was leaving his practice because his unit of the Nevada National Guard had been called to active duty, and it needed a replacement. Dr. Petty took on the job. He served on the Board of Medical Examiners from 1941 until 1943, taking Dr. Anderson's place on the Board as well as in his medical practice. Dr. Petty also interrupted private practice to serve in the navy, but returned to

both Carson City and the Board of Medical Examiners. He was again appointed to the Board in 1961.

Dr. Petty remembers the shifting of medical personnel that was necessary as doctors went off to war:

> In Nevada we had a program for doctors called Procurement and Assignment. They took a young doctor from one community and put them in another where they were needed. In this particular instance, Virginia City was folding because the precious metals were declining, and they brought Dr. George Ross from Virginia City down to take over the practice. He was secretary of the State Board of Medical Examiners for a long time, too, during the war.[40]

Many Nevada physicians were among the twelve million individuals who served in the wartime military, and the experience had a profound effect on their lives. The war itself, beyond social and political significance, caused important advances in the practice of medicine and issues of public health. The development and use of new drugs, improved drugs, more effective trauma treatment, and the use of blood products — all of these medical progressions affected physicians and their patients, postwar as well as during the conflict.

Medical Practice Act Revision, 1949

Dr. Fred Anderson served on the Board of Medical Examiners in the early 1940s. In his recollection of his life in medicine, he complained about the politics that he encountered in his time on the Board. Soon after his appointment he worked with Alan Bible, who was the Board's counsel and later U. S. senator from Nevada, to rewrite the Medical Practice Act. The new bill was introduced and passed unanimously in the assembly. There was a problem, however, in the senate where the bill was bogged down in committee. The chair of the committee, Senator Noble Getchell, was vague about the reasons for the delay. Dr. Anderson made some inquiries and concluded that a few of the older Reno doctors "didn't like having upstarts messing with their laws, however archaic," and used their political influence to stall the bill. After his postwar return to Nevada and medical practice, Dr. Anderson was "interested" to learn that the bill he worked on was passed, in 1949, with little change and no opposition.[41]

Politics aside, the Medical Practice Act was completely revised in 1949. Rather than amending the existing act, the entire law was repealed and a new law put in its place. The language was more modern, the powers and duties of the Board very specific. It is an interesting contrast to the first Medical Practice Act of 1905 — both similar and different — but the increase in the Board's authority is apparent.

The 1949 law was particular in its exclusion of certain medical practitioners from the supervision of the Board:

> This act shall not in anywise apply to the practice of dentistry, osteopathy, chiropracty, chiropody, optometry, faith, or Christian Science healing, nursing, veterinary medicine or of an herbalist . . . . [42]

The Board, however, was given the right to examine "any person pretending to a knowledge of any branch or branches of medicine, surgery, or obstetrics not provided

for elsewhere in the statutes of Nevada." Both specific and very generalized authority over medical practitioners was given to the Board.

There was also a change in the training requirements. Applicants were required to have served a one-year internship in the United States in a program accredited by the AMA. They also had to be U.S. citizens, although graduation from a Canadian school was acceptable. Older physicians were grandfathered in, with seven years of medical practice as a substitute for an internship.

Habitual intemperance involving either drugs or alcohol had been added to the definition of misconduct in 1929. In 1949, prescribing narcotic drugs (opium, coca leaves, and cannabis were specified) for the "purpose of catering to the cravings of an addict" was considered misconduct.

The alterations to the Medical Practice Act continued through the 1950s, 1960s, and 1970s, with the changes reflecting the mood of the state and the personalities of legislators and Board members. Appointments to the Board were made by the governor, a requirement that dates from the 1899 legislation. In 1905, it was specified that the Board members would be chosen "without regard to their individual political beliefs"; that was one requirement that was easier to mandate than to achieve. *If* politics was not a part of the appointment process, it was not for lack of politicking.

Complaints and Politicking

As noted, the governor of Nevada makes appointments to the Board of Medical Examiners. While the legislature periodically has reworked the laws that gave the Board authority, it has been to the governors that many of the appeals and complaints about the Board, its members, and its actions have been directed. The correspondence of several of Nevada's past governors provides insight into some of the concerns expressed about the Board.

One issue that persists to the present concerns geographical distribution of Board representation. Dr. T. O. Duckworth, according to his letterhead, was Surgeon in Charge of the Duckworth Hospital in Pioche. In 1915 Dr. Duckworth wrote to Governor Emmet Boyle, following up on an earlier conversation about an appointment to the Board. Dr. Duckworth was concerned about the lack of representation from southern Nevada. He suggested that someone from Lincoln County be appointed to either the Board of Medical Examiners or the Board of Health. His own aspirations (and difficulties with either spelling or typing) were expressed when he mentioned to the governor:

> . . . in the event you should be favorably inclined of course would like to land the plum my self as I am the only one of the Physicians in Lincoln county that is a Democrat. and my past training in this line I considder make me especially prepaird to fill the place.[43]

Governor Boyle's response pointed out that, regrettably, there was no position available on the Board at that time. He was also careful to note that he had made none of the appointments to the Board. The previous governor, Tasker Oddie, had filled the positions before his departure from office.

Dr. Duckworth's letter expresses his opinion that an appointment to the Board of Medical Examiners was a "plum." Similar sentiments were expressed over the decades as physicians and their supporters lobbied subsequent governors for a place on the

Board. Politics could be a factor in suggestions for physician appointments to the Board. A 1927 letter in support of an appointment for Earle Creveling, a member of the Board from 1933 to 1949, reminded Governor Balzar that, "At Reno there is a good Republican, who was active in your support . . . . "[44]

Governors were subjected to complaint about the action of the Board, as well as importunities for Board appointments. In 1916 Dr. R. C. Kirkwood was surgeon for the Elko Prince Leasing Company in Midas, Nevada, a gold mining town in western Elko county that boomed around the turn of the century. Dr. Kirkwood, in a letter to Governor Boyle, expressed his anger over the apparently contradictory operation of the Board.[45]

Dr. Kirkwood charged that the Board, "or at least the Secretary thereof, is disposed to insist upon strict compliance with the law in the case of reputable practitioners seeking license in Nevada and let an acknowledged charlatan practice without license." A recent arrival in the state, Dr. Kirkwood had presented medical credentials to the Board, and had received in response a form for the Pennsylvania medical board to complete. Dr. Kirkwood was insulted by the Board's warning admonition that he would be prosecuted if he practiced medicine before he had received his license.

Dr. Kirkwood was willing to comply with Nevada's requirements but he was outraged when it appeared that the law was not uniformly enforced. Dr. Monk, a "charlatan," was practicing without a license in Midas with the "full knowledge of the Sect. of the Board of Medical Examiners without any action by that official," Kirkwood informed the governor. He charged that the man was not practicing "reputable" medicine, claiming to "'cure'" typhoid fever, and treating, for fifty dollars, pyorrhea in a patient who did not have the condition. Dr. Kirkwood claimed that the disreputable physician was an alcoholic, and "therefore in with the saloon element, very strong here."

Dr. Kirkwood noted that the matter had been brought to the attention of the Board, and that Dr. Lee had admitted, "Monk is a fraud and should have been prosecuted long ago." Although he would soon be leaving town, and relocating to Washington, Dr. Kirkwood was concerned about the fraudulent medicine. He believed that: "The Sect. of your Board of Medical Examiners needs to have his vision of right and justice refracted. It is astigmatic at present."

The matter was quickly resolved. Four days after his initial letter, Dr. Kirkwood again wrote to the governor, asking that his first letter be disregarded. He had been reassured in a letter from Dr. Lee that any inactivity was not the fault of Dr. Lee, and stated, "I am sure he is not to blame for conditions here." The exact nature of Dr. Lee's problems with Dr. Monk remain a mystery, but for Governor Boyle and Dr. Kirkwood, the issue was effectively settled.

One letter of complaint that Boyle received in 1920 was from an eclectic physician who had failed the Board's examination. Dr. J. W. Gerow had requested an examination in materia medica, therapeutics, and the theory and practice of medicine, but he was refused. He reminded the governor that he was entitled by statue to an examination by a Board member from his school of medicine; this was indeed a part of the 1905 Medical Practice Act. Dr. Gerow also claimed that the secretary of the Board, S. L. Lee, had told him that he would receive "seniority credit" because of his eighteen years of practice, and thus he needed a grade of only a 61 percent to pass the exam. Part of Dr. Gerow's complaint was that he had received information that one

member of the Board had remarked that he would not pass the examination under any circumstances, but he could not prove this allegation. There is no record of the governor's response, although a letter to S. L. Lee from Dr. S. K. Morrison, who was a member of the Board, supported the appointment of John Lewis and noted that "he would qualify as a Homeopath and thus the Board would be again organized according to law and Gerow."

Correspondence with governors about the Board has been more than petitions for appointments and complaints. One Reno attorney thought to use a medical license as further proof of a divorce client's residence in Nevada. In 1932, George Springmeyer wrote to Governor Fred Balzar, explaining that he had a client who was "anxious to make his residence in Nevada solid and unquestionable by way of being admitted to practice medicine in the State of Nevada." Mr. Springmeyer requested the governor's intercession with the Board, within the limits of "propriety," to facilitate his client's license. He wished to avoid having his client "put to the expense and burden and trouble of taking the medical examination in Nevada."[46] There is no record that his client, Dr. Richard Price, was granted a license in the early 1930s.

The state of medicine in America and Nevada is reflected to a certain extent in the legislation that created the Board and a method for medical oversight. The primary purpose of the Board, at least on paper, was to safeguard the health and medical welfare of the citizens of Nevada. If that purpose was sometimes obscured in the personalities and agendas of the individuals who appointed and administered the Board, it was not without precedent. The Board members, however, took their job seriously, and the standards of medical care and physicians in Nevada were undoubtedly improved in the first half of the twentieth century. The Board and their standards were strengthened and expanded even more in the next forty-five years.

Notes

1. Shryock, vii, 5.

2. Duffy, 69; Cassedy, 19.

3. Shryock, 19-23.

4. Starr, 57.

5. Duffy, 291.

6. Starr, 226.

7. Ronald L. Numbers, "The Rise and Fall of the American Medical Profession," Leavitt and Numbers, 189.

8. Starr, 106.

9. Ibid, 103-104.

10. Henry Cutting, *The Compiled Laws of Nevada, 1861 to 1900* (Carson City: State Printing, 1900), 973.

11. *Statutes of Nevada*, 8th sess. (Carson City: State Printing Office, 1877), 69.

12. Ibid., 73.

13. Steven Mintz and Susan Kellogg, *Domestic Revolutions: A Social History of American Family Life* (New York: Free Press, 1988), 110.

14. M. R. Walker, *A Life's Review and Notes on the Development of Medicine in Nevada from 1900 to 1944* (Private Printing, 1944), 15.

15. Ibid., 15-16.

16. *Appendix to Journals of Senate and Assembly of the Seventeenth Session of the Legislature of the State of Nevada* (Carson City: State Printing Office, 1895), Report 22, 4.

17. An important aspect of physician oversight in Nevada has been the organization of county and state medical societies. Their histories, however, are beyond the focus of this work.

18. Charles McIntire, M.D., "State Requirements for the Practice of Medicine," *Bulletin of the American Academy of Medicine* 2 (February 1897): 700.

19. Ibid.

20. Nevada Legislature, *The Journal of the Assembly*, 19th sess. (Carson City: State Printing Office, 1899), 58.

21. Ibid.; *Statutes of Nevada*, 19th sess. (Carson City: State Printing Office, 1899), 89-90.

22. *Reno Evening Gazette*, 19 January 1899.

23. Ibid., 11 February 1899.

24. Ibid.

25. *Statutes of Nevada*, 19th sess. (Carson City: State Printing Office, 1899), 88; Starr, 107.

26. *Reno Evening Gazette*, 1 May 1899.

27. S.L. Lee, M.D., "Biennial Report of the Board Medical Examiners, 1899-1900," *Appendix to Journals of Senate and Assembly, Twentieth Session* (Carson City: State Printing Office, 1901), 3-8.

28. S.L. Lee, M.D., "Biennial Report of the Board Medical Examiners, 1901-1902," *Appendix to Journals of Senate and Assembly, Twenty-First Session* (Carson City: State Printing Office, 1903), 5-11.

29. *Statutes of Nevada*, 22d sess. (Carson City: State Printer, 1905), 87-93.

30. Correspondence, 4 December 1919, A.R. DaCosta to Governor Emmet Boyle, Nevada State Board of Medical Examiners' File in Governor's Records, box GOV-0030, file 023, Nevada State Archives, Carson City, Nev.

31. The Thirty-First Session of the legislature in 1923 altered Section 2 of the Medical Practice Act, deleting the specification that of the five physicians on the Board of Medical Examiners, three would represent the Regular School, one would represent the Homeopathic School and one the Eclectic School. The Amended act required "reputably practicing physicians . . . who have been actually engaged in the practice of medicine in the State of Nevada," without specifying medical systems. *Statutes of Nevada*, 31st sess. (Carson City: State Printing Office, 1923), 280.

32. Correspondence, 16 March 1936, A. R. DaCosta to Governor Richard Kirman, Nevada State Board of Medical Examiners' File in Governor's Records, box GOV-0087, file 033, Nevada State Archives, Carson City, Nev.

33. Cassedy, 88.

34. Letter from Earle L. Creveling to E. E. Hamer, M.D., 8 August 1928. Arnell Cheatham file, Nevada State Board of Medical Examiners' office, Reno, Nev.

35. *Statutes of Nevada*, 32d sess. (Carson City: State Printing Office, 1925), 66; *Statutes of Nevada*, 34th sess. (Carson City: State Printing Office, 1929), 38-41, 142.

36. Dr. Edward E. Hamer to Dr. Thomas W. Bath, 19 November 1928, letter in Arnell Cheatham file, Nevada State Board of Medical Examiners' office, Reno, Nev.

37. *Statutes of Nevada*, 35th sess. (Carson City: State Printing Office, 1931), 345-349; *Statutes of Nevada*, 38th sess. (Carson City: State Printing Office, 1937), 162-166.

38. *Statutes of Nevada*, 41st sess. (Carson City: State Printing Office, 1943), 170-171.

39. Elliott, *History of Nevada*, 312.

40. Dr. Richard Petty interview, November 1994. Dr. George Ross was on the Board from 1943 to 1959.

41. R. T. King, *Frederick M. Anderson, M. D.: Surgeon, Regent and Dabbler in Politics* (Reno: University of Nevada Oral History Program, 1985), 91-92.

42. *Statutes of Nevada*, 44th sess. (Carson City: State Printing Office, 1949), 348-357.

43. Letter from T. O. Duckworth to Governor Emmet Boyle, 1 February 1915 in Governor's Records, box GOV-0019, file 008, Nevada State Archives.

44. Letter from Clyde D. Souter to Fred B. Balzar, 17 May 1927, in Governor's Records, box GOV-0059, file 016, Nevada State Archives.

45. Letter from R. C. Kirkwood, M. D. to Governor Emmet Boyle, 20 July 1916, in Governor's Records, box GOV-0019, file 008, Nevada State Archives.

46. Letter from George Springmeyer to Fred B. Balzar, 16 July 1932 in Governor's Records, box GOV-0070, file 022, Nevada State Archives.

4

The Board of Medical Examiners: Recent Issues

The functions of the Board of Medical Examiners have become increasingly complex since its establishment nearly a century ago. In part, that complexity is a result of changes in medicine in an ever modernizing and swiftly changing society. Much of the change, however, can be directly related to specific issues related to medicine and the practice of medicine that the Board has had to confront, sometimes willingly, sometimes reluctantly.

Alternative Medicine

Originally, the Board of Medical Examiners was composed of physicians representing different schools of medical practice. By 1923 the Board was officially comprised of physicians representing allopathic medicine. Control of the variety of styles eventually diversified and different supervisory boards emerged to govern colleagues with a shared vision in their approach to health and medicine. The Board of Medical Examiners, mandated to protect the people of the state, was sometimes caught in the middle of debate over freedom of choice for medical care.

Osteopathic Medicine

Osteopathy is a relative late-comer to the medical sects. It emerged, as did Christian Science, in the 1890s and gained acceptance as homeopathy and the eclectics were declining in popularity. As with the other sects, the theory of osteopathy resulted from dissatisfaction with the heroic approach to medicine. In 1874 a rural Missouri physician, Andrew Still, began to develop a mechanistic approach to health and the unity of body parts.[1] He believed that the human body was like a machine: the heart was an engine, the lungs a fanning machine, the brain a battery. For the machine to function properly, the parts had to be in a correct relationship.

Dr. Still established a school to teach his theories in 1892 and had gained legal protection in Missouri by 1897. Osteopathy was never absorbed into the regular medical establishment like the homeopaths and the

eclectics.[2] It stayed independent and evolved over the course of the twentieth century into a legitimate medical alternative, though the numbers of physicians and patients were low compared to allopathic practitioners.

Allopathic physicians have been scathing in their denunciation of alternative medical practices. In 1925, Dr. Morris Fishbein, M.D., editor of the *Journal of the American Medical Association*, published a collection of his essays. The title reveals the theme of the contents: *The Medical Follies: An Analysis of the Foibles of Some Healing Cults, Including Osteopathy, Homeopathy, Chiropractic, and the Electronic Reactions of Abrams, with Essays on the Antivivisectionists, Health Legislation, Physical Culture, Birth Control, and Rejuvenation*.

Osteopathy was one of the medical beliefs that Dr. Fishbein denigrated. He introduced his essays with epigrams; the one chosen for osteopathy began, "Despite our remarkable advance of knowledge, nonsense is ever becoming bolder and more rampant . . . " He went on to describe Andrew Still's autobiography as, "a True piece of Americana, remarkable for the crudeness of its style, its florid diction, its religious frenzy and exaltation." People patronized osteopaths, Dr. Fishbein concluded, because they were approached through advertising, "in which reputable physicians do not indulge." They believed in osteopathy because of the temporary benefit or feeling of benefit that comes with a "laying on of hands." He warned of the great damage that the "cultists" could cause.[3]

In Nevada, there was support for osteopathy and a bill regulating the practice of osteopathic medicine was passed in 1925. As defined in the statute it is "a healing art which places the chief emphasis on the structural integrity of the body mechanism." The law relating to osteopaths was even more specific than that for allopaths, requiring attendance at a legally chartered osteopathic school or college for thirty-six months. The statute for allopaths required only a diploma from a legally recognized college without specifying a time period. This was undoubtedly a response to the problems of previous decades when proprietary colleges had turned out hordes of doctors who had attended school for eight months or less. Although medical colleges were being reformed, there was a lingering caution toward medical education.[4]

Osteopaths currently have the same educational requirements as allopaths, and, nationally, similar licensing requirements. The regulatory boards in twenty-five states and the District of Columbia are comprised of both M.D.'s and D.O.'s. In eleven states D.O.'s are regulated by M.D.'s; and fourteen states have separate boards, with D.O.'s licensing and disciplining D.O.'s. The struggle of the past between medical groups is not forgotten, however. That memory is evident in a statement in a pamphlet distributed by the American Osteopathic Association: "The osteopathic profession believes all patients should have the right to select the kind of health care they prefer. It also believes that no single group of physicians, and no single political organization, should hold a monopoly on health care."[5]

Oriental Medicine

One of the more controversial issues that surfaced regarding medical practice was the debate over acupuncture in 1973. In November of 1972 a Chinese physician, Dr. Lok Yee-Kung of Hong Kong, applied to the Board of Medical Examiners for a temporary medical license in order to legally demonstrate the technique of acupuncture.[6]

Dr. Lok's request was refused, and the Board drafted a formal statement of their position, prefacing their opinion with the following assertion:

> The objective, purpose and function of the State Board of Medical Examiners is to insure the best medical care for the people of the state and to protect the citizens in all ways so that best possible medical care is obtained and to protect the people of Nevada from methods which have not been scientifically proven."[7]

In March, 1973, the Committee on Health, Welfare, and State Institutions passed an emergency bill allowing a demonstration of acupuncture for the legislature. A clinic was set up in the Ormsby House Hotel and Casino in Carson City to provide a place for Dr. Lok to work, and he performed acupuncture there over a period of several weeks. The effort to legalize the Chinese medical technique was backed by a New York attorney and real estate developer, Arthur Steinberg, who had retired to Las Vegas. Mr. Steinberg had started the American Society of Acupuncture, Incorporated, in Las Vegas, and he indicated to the Board that he wanted Dr. Lok to start a college there. The acupuncture issue was well publicized. A Las Vegas public relations firm, May Advertising Company, was involved, and, in the words of the supporters of Oriental medicine, "helped spread the word."[8]

The concerns of physicians practicing regular medicine were centered around a lack of understanding and common ground between Western and Chinese medicine. In their position statement, the Board of Medical Examiners acknowledged that "although acupuncture has been an important part of the theory and practice of Oriental Medicine for several centuries, its concepts and uses are not understood by Western medicine."

The Board also expressed concern about the lack of Western scientific investigation and knowledge of the philosophical basis for acupuncture and the anatomical mechanism by which acupuncture provided pain relief:

> Very little scientific literature on this topic has been published in Western nations or even in China. Because of the lack of understanding by Western medical scientists, and because of potential harm which acupuncture might produce in patients for whom the treatment of symptoms would mask a serious or perhaps fatal condition otherwise amenable to treatments aimed at the cause . . . acupuncture is not sufficiently well understood to be an acceptable method for use in the practice of medicine in this State.[9]

In Arthur Steinberg's meeting with the Board the issue of Western-style scientific investigation was raised. Members of the Board suggested investigation of acupuncture with evaluation of treatment and long-term follow-up; but Steinberg indicated that members of the legislature wanted evaluation before treatment, then immediate appraisal after treatment. Dr. Kenneth Maclean stated at the meeting that evaluation of the efficacy of acupuncture should be determined in an approved research center, and he expressed doubts that legislators were qualified to evaluate a patient.

Arthur Steinberg appealed to the Board on behalf of the people of Nevada and those unfortunates who did not have the financial resources to fly to Hong Kong for acupuncture treatment. According to Steinberg, Dr. Lok's

credentials were unquestionable and his ability recognized all over the world. Further, Mr. Steinberg believed that denial of a permit for Dr. Lok to demonstrate his skill for the legislature would postpone acupuncture for 100 years, presumably in part due to the lack of a college of Oriental medicine in Nevada. The responsibility for such a deficiency would rest with the Board.

When the bill concerning Chinese medicine came before the legislative committees there was a great deal of evidence offered to support both sides of the issue. Much of the testimony, as described in meeting minutes, was "very emotional in this appeal." The Nevada State Medical Association supported passage of A.B. 673, which would allow for evaluation of the potential hazards and benefits of acupuncture, and the Board of Medical Examiners expressed support for that legislation rather than the bill regulating separate practice of Chinese medicine.

Investigation done for the New York state legislature by the University of New York was submitted as evidence. That study noted that although acupuncture was an ancient method for pain treatment and anesthesia, even in the People's Republic of China a "'Western-style' medical diagnosis [was done] prior to the administration of acupuncture." Acknowledging that there had been positive results with the use of acupuncture, the report warned of the potential hazards of harmful side-effects, transmission of infectious diseases, and masking of the development of serious medical conditions. Further evidence in the form of an article from *Medical World News* reported that research from the National Institutes of Health had resulted in a "mixed bag" for acupuncture. There were still significant questions to be answered about "what acupuncture can and cannot do".[10]

During the hearings, the credentials of Dr. Lok were questioned. Arthur Steinberg's letter to the Board of Medical Examiners had asserted that Dr. Lok had been practicing acupuncture since 1924, apparently beginning his training at age twelve. Further,

> He is one of the few Chinese master acupunctuers [sic] in the world. He is licensed to practice traditional Chinese medicine which includes acupuncture. He is President of the Hongkong Association of Acupuncturists, President of the Hongkong College of Chinese Acupuncture, President of the Kowloon College of Chinese Medicine, and Honorary President of the Kowloon Association of Chinese Medicine.

When the president of the Nevada State Medical Association, Dr. John Sande, inquired of the Hong Kong Medical Association about the credentials of Dr. Lok, the reply was that "'Professor'" Lok was not a "registered medical practitioner in Hong Kong. He has no medical qualifications and has no standing in the local medical profession. Apparently he is a herbalist and is a self-appointed professor." The Kowloon Chinese Medical Society did not respond to inquiries.[11]

In discussion with the Senate Committee on Health, Welfare and State Institutions, Senator Herr questioned the medical community's interest in acupuncture "all of a sudden . . . when, in fact, acupuncture has been in existence for thousands of years?" When the senate committee was urged to consider the welfare of the people, Senator Neal replied that "the committee did indeed have the welfare of the people in mind, and its responsibility was to provide health care

to those people. Further, that if the AMA was not prepared to accept this responsibility, that this committee was ready, willing and able to accept it for them."[12]

Physicians who were members of the Board of Medical Examiners, and others who were practicing in the state at the time, were concerned over the dissimilarities between Chinese and Western medicine. The motives for and the process by which the legislation was enacted were suspect.

Dr. Theodore Jacobs saw the differences in Western allopathic medicine and Oriental medicine as basic ideological incompatibility, though he conceded that "One has to be impressed with certain case studies that come forward and how efficacious it is in certain instances, particularly in the delivery of anesthesia." In the end, however: "East is East and West is West and ne'er the twain shall meet — I just don't think our thinking is on the same wave length as Eastern medicine." The lack of discussion over possible negative effects was also a concern that Dr. Jacobs expressed:

> If all these forces that exist within the body that acupuncture attacks for the benefit of the patient — if for some reason those needles were put in in the wrong places, why wouldn't that have a negative effect? Certainly if we used wrong medications for people in certain cases we may get negative effects in the disease process. It always seems that people who espouse acupuncture never discuss the possibility of bad results because of misplaced needles.[13]

Dr. Kirk Cammack's disquiet over the practice of acupuncture was more personal. He had seen acupuncture and related therapies used in Vietnam:

> I operated on over forty ruptured appendices over there, and I don't think that maybe three or four of them had not had acupuncture first. I'm sure there's a place for acupuncture in pain control, but it's certainly not for ruptured appendices or for tuberculosis and many organic diseases that they claim cure for.[14]

The motive for the licensing of acupuncture and the type of lobbying that was done to promote the bill irritated Dr. Leslie Moren:

> We fought the separate board of acupuncture tooth and toenail, but the fellow who was promoting it from Vegas, he spent one hundred thousand bucks to campaign. He gave acupuncture treatments to some of the legislators and the committee. They thought it was great. The guy who was setting it up was going to have franchises, like McDonald's, all over the state. We had one here in Elko, but it didn't last too long. We learned that one of the big proponents had been a tailor in Hong Kong a couple of years before, but [now] he was an acupuncture specialist.[15]

Dr. Richard Grundy was on the Board when the lobbyist hired by the acupuncture interests approached the Board for a temporary license to demonstrate. The credentials that were presented were in Chinese, and the Board wanted to get the information translated into English. The lobbyist protested that there was no time for that, so the application for a temporary license was denied. As Dr. Grundy recalls,

> I was the one that told him that. And I never will forget — I was sitting

> in the chair, and he was standing up, and he looked down and he said, "Grundy, he will have a license to demonstrate acupuncture in January; I guarantee it," and walked out. And he did. [The lobbyist] Joyce got the legislature to pass the law to give him a license to demonstrate acupuncture to the legislature during the month of January.

Like other allopathic physicians, Dr. Grundy objected to acupuncture as "unscientific." He allowed that "just because you can't explain it doesn't mean that it's not possible." He did have experience with patients who had a "significant amount of damage" from treatment:

> I remember one guy who had back pain. He went and saw an acupuncturist, who put needles in his hip down there, and then applied some electrical current to them. And somehow he got close enough to the sciatic nerve just to burn the hell out of that guy. He's still around; he still limps from the damage to that sciatic nerve. But on the other hand, I have had other people who have said that it has very definitely relieved their pain, where I didn't. So I'm not willing to say it's all a bunch of baloney, but medicine, you know, accepts things quite slowly. And I can't help but think that's a pretty good idea.[16]

Those supporting acupuncture were not willing to wait for the slow process of acceptance by regular medicine. The lobbying efforts behind Chinese medicine were effective, and S.B. 448 was passed. The bill legalizing Chinese medicine in Nevada was signed by Governor Mike O'Callaghan in April, 1973 and the Board of Chinese Medicine was created at that time.

Homeopathic Medicine

The disagreements between allopathic medicine and homeopathic medicine date back to the nineteenth century. A number of medical historians have pointed to homeopathy as the most important challenge to allopathic hegemony, and there was struggle and conflict between the two branches of medicine. Allopathic medicine, however, eventually gained preeminence nationally and in Nevada. The nineteenth century beginnings of homeopathy were reviewed in Chapter One, and an early twentieth-century clash between homeopaths and allopaths related to legislation was detailed in Chapter Three.

Discord between homeopaths and allopaths is a recurring theme in Nevada medical history. Early conflict between physicians that erupted in Virginia City serves as a backdrop for further confrontation more than a century later. In 1868 two allopathic physicians charged a homeopath with carelessness and lack of professional standards. Dr. F. Hiller surgically treated John Grey, who had severely injured an arm and shoulder in a fall. Dr. Hiller administered chloroform to Mr. Grey, while the patient was seated in an office chair, and removed splinters from the affected area. Mr. Grey died during the surgery.[17]

Dr. Hiller was one of many physicians and healers espousing a variety of medical theories in Virginia City in the 1860s. In the advertisement for his practice, Dr. Hiller explained the benefits of homeopathy in some detail. According to Dr. Hiller the aim of his approach to medicine was to "eradicate

disease entirely, to cure sure and easy, without bleeding, blistering, cauterizing or drugging, to prolong life and lessen the number of sick days." The experience of homeopathy had proved "that one-half those dying at an early age can be saved." To support his claim, Dr. Hiller had statistics that clearly demonstrated superiority over allopathy. Comparing mortality rates for general disease, cholera, typhus fever, yellow fever, and pneumonia, Dr. Hiller claimed that many more treated by allopaths died. For example, the allopathic mortality for cholera was 49.57 percent, but for homeopathic it was much lower — 16.83 percent.[18] The source for the figures is not indicated.

The disdain for heroic medicine was obvious, and two orthodox physicians, Drs. Bryarly and Cleburne, took the opportunity to attack the competency of a homeopathic physician. They charged that Dr. Hiller had been negligent. According to the allopaths, he had failed to properly examine the patient and had used too much chloroform on a patient who was improperly positioned. Dr. Hiller defended his positioning of the patient by citing a Dr. Snow's successful use of the position for 949 cases. Hiller maintained that Mr. Grey died of apoplexy; when the patient had first exhibited distress during surgery, Dr. Hiller bled him in the left arm and jugular to relieve congestion of the veins of the head and neck. The controversy was played out on the pages of the *Territorial Enterprise*, and Dr. Hiller's defense of his medical skill and practice was, in essence, a defense of homeopathy.[19]

The disagreements between homeopaths and allopaths that resulted in the 1923 change of the Medical Practice Act were less public, but protracted and subtly rancorous. By the 1930s the dominance of regular medicine was virtually unchallenged, and homeopathy was a minor medical sect. By the 1980s, however, homeopathy was regaining popularity as a medical alternative, and it was again seeking statutory legitimacy.

In the 1983 legislative session, Senate Bill No. 237 created the Board of Homeopathic Physicians. During testimony before the Committee on Commerce and Labor, the history of homeopathic medicine was recounted, looking back to Hahnemann and the work of he and his followers in their "provings" of minuscule doses of medical substances. The modern practice of homeopathy uses animal, vegetable, and mineral remedies, herb and botanical medicines, even morphine, cocaine, and arsenic; all, however, are utilized in infinitesimal doses. Homeopaths maintain that seemingly ineffective substances, such as sand, charcoal, salt, and pencil lead, could be helpful when given to the right patient. The basic precept is that, "Homeopathy is essentially natural healing; the remedy assisting the patient to regain health by stimulating nature's vital forces of recovery."[20]

F. Fuller Royal, a Las Vegas homeopathic physician, submitted an article that he had written as an exhibit for the committee. He explained both the history and the modern practice of homeopathy, and outlined the commonalities and the differences between homeopathy and allopathic medicine. Both, he noted seek to "cure the sick, prevent others from becoming ill, and to raise the standard of health in all people." Homeopathy, however, seeks to move beyond allopathy to look at the patient as an individual and treat the constitutional cause of disease rather than simply relieve symptoms, as Dr. Fuller maintained that regular drug therapy does.

The supporters of the bill to regulate homeopathy were apparently preaching to the converted. Several legislators attended

the committee meeting with their own stories to tell of the efficacy of homeopathic treatment. During the Commerce and Labor Committee meeting, April 8, 1983, Senator James Gibson told those present that his interest in homeopathy was personal because members of his family had been treated by homeopathic physicians. Senator Floyd Lamb commented that he was a "living example of what homeopathic medicine had done for him." Senator Lamb then related a story about an ex-wife who needed to borrow money to finance surgery for her knee; he took her instead to a [homeopathic] clinic for treatment, and within three days she was playing golf and riding horses. Senator Helen Foley supported the senate bill because she had family members who had benefitted from homeopathic medicine when allopathic treatment failed. Her father's high blood pressure had not responded to conventional treatment. When she took him to the homeopathic clinic, they determined that he had had a "bad reaction" to a typhoid shot in the 1940s and further explained that the antibodies from the reaction remained in the bloodstream. Senator Foley did not explain the connection between the typhoid reaction and blood pressure, nor did she specifically reveal her father's homeopathic treatment or results. Senator Lamb elaborated on his support at a later Assembly Committee on Commerce hearing, May 9, 1983, when he declared that he believed that he was alive because of homeopathic treatment he had been receiving for two years following a heart attack.[21]

The Nevada State Medical Association, in a letter to the commerce committee, supported the use of homeopathic practices if employed by trained and licensed physicians. The medical association objected, however, to the creation of a separate homeopathic board. Gordon L. Nitz, president of the association, expressed concern in his letter that "this duplication [of Boards] may be an avenue for abuse and that the existing Board of Medical Examiners is the place for licensing medical doctors, regardless of their specialty." The medical association supported amendments "to incorporate more fully homeopathic practitioners into the mainstream of Nevada [medical care]."[22] In a second letter from the Nevada State Medical Association, H. Treat Cafferata, Chairman of the NSMA Governmental Affairs Commission, reminded the senate committee that an advisory board to the Board of Medical Examiners on homeopathic medicine created two years earlier had not been consulted by physicians wishing to practice homeopathy. He pointed out that there were only four homeopathic physicians in the state, which strengthened his belief that separate oversight was unnecessary.[23]

The homeopathic supporters persisted in their advocacy of a separate board, asserting that there was a lack of understanding of homeopathy in the medical field. Senator Keith Ashworth had testified that the "State Board of Medical Examiners showed an insensitivity toward other medical service professions in the past."[24] In his testimony Ray Rothwell, president of Blue Shield of Nevada, expressed concern that the rigid requirements for medical licensing demanded by the Board of Medical Examiners would not be required by the Homeopathic Board.

The enthusiasm for homeopathic medicine prevailed over such concerns. Senate Bill No. 237 was passed in amended form in the sixty-second session, and homeopathic medicine received its own regulatory and licensing board.

Physician's Assistants

As medical technology expanded in the mid to late twentieth century, the variety of

personnel involved in medical fields increased to meet the needs of modern medicine. Oversight of paramedical personnel has been left to the licensing and examining boards closest to the profession served. In 1968 the Board of Medical Examiners advised the legislative counsel that "in the growing area of paramedical personnel, the board feels that it is extremely important that there be a provision in the statutes enabling such personnel to be examined and licensed if the need and occasion arises."[25] The change was instituted in 1973, when the Medical Practice Act was revised to incorporate oversight of physician's assistants (P.A.'s) into the responsibilities of the Board. As defined by the statute, physician's assistants were individuals who were graduates of an academically approved program or those who were "by general education, practical training and experience" qualified to "perform medical services under the supervision of a supervising physician."[26]

The intent of the physician's assistant program was to provide medical care for rural areas that did not have an available physician, or, as Dr. Jacobs phrased it, "to help out in the rural areas." Those P.A.'s who do work in rural areas are often some distance from the supervising physician, communicating, like ranch families, by telephone. One physician's assistant working in Elko, Nevada, in 1995, reports to a physician in Twin Falls, Idaho.

Dr. Norm Christensen, who practices in an isolated small-town area, understood the physician's assistant program to be a temporary measure, a stop gap until medical education produced enough doctors to supply everyone's needs. Dr. Christensen opposed the program and did not feel that it was necessarily productive, although "I may recant a little bit on my original feelings, but not totally, you know. Upon being given the choice between the family practitioner and a P.A., I want the family practitioner."

From 1973 to 1994 the Board of Medical Examiners licensed a total of 229 physician's assistants; there were eighty-two P.A.'s licensed for calendar year 1994. The majority of the active physician's assistants were working in Las Vegas in 1994.[27] The concentration of physician's assistants in urban areas is not surprising, because, as Dr. Thomas Scully observed, "P.A.'s have reflected what's gone on in medicine. Many of them have become sub-specialized. There are P.A.'s who do just heart work, and there are P.A.'s who do orthopedic work, and there are P.A.'s who do family medicine."[28] The physician's assistants, then, have settled where the specialists work, in the urban areas.

That concentration is undoubtedly natural in a state like Nevada. Looking back, Dr. Scully believes that:

> The original idea that they would be essentially practicing rural medicine was sort of naive in the first place. When you think about it, with the population of rural Nevada, if you provided ten P.A.'s and twenty doctors tomorrow, it would probably take care of all the needs of most rural communities.

If the original intent of the program has not been fulfilled as hoped, the program has been a success. As Dr. Jacobs noted, there have been relatively few problems:

> I think all of us on the Board have been very impressed with the quality of the physician's assistants. We've had very few problems with the physician's assistants themselves. Some of their problems have been from the lack of

> proper supervision by supervising physicians. So, I think, in general we've been happy with the program, with the exception that a lot of them ended up in urban areas rather than rural areas where they were really needed.[29]

The Open Meeting Law and Public Members

An important catalyst for change at the Board of Medical Examiners was the institution of the Open Meeting Law and the addition of public members to the Board itself in 1977. The national movement for opening government activity to public scrutiny and participation began in 1950, with the Freedom of Information Committee for the American Society for Newspaper Editors. The Brown Anti-Secrecy Act was passed in California in 1953, prompting other states to follow its example. Nevada passed an Open Meeting Law based on California's statute in 1960.[30]

Bowing to further demands for more public observation of the bureaucratic process, the Nevada legislature revised the Open Meeting Law in 1977, but excluded lawmakers themselves from scrutiny. That discrimination was an unpopular move that was criticized in the press: "[Excluding the Nevada Legislature] is a self-serving amendment, designed to grease the bill's passage through the narrow halls of the legislature and should be removed."[31]

The requirement that meetings be open to the public, and that notice of such meetings be posted, created a problem for the Board of Medical Examiners. Larry Lessly, counsel for the Board, discussed some of the drawbacks:

> . . . There're a lot of things that the Board does with a physician that ought to remain confidential until a decision is made. If you simply go out and start investigating a physician, and the public has a right to be present when you're doing that investigation, there are a lot of things [brought out] that don't need to be made public. If a decision is made that there's no problem with that physician's conduct, the news media's already picked up the fact that he's under investigation, and his practice is ruined.[32]

The investigative aspects of the Board's activities were exempted from the Open Meeting Law as part of the 1985 revision. In 1987 concern over impaired physicians prompted legislators to question such confidentiality. The Board supported the position that a physician who is in treatment, and is fulfilling the stipulations of his contract, is not impaired. Confidentiality was retained.

Part of the response to the movement for more public access and involvement in government was citizen oversight of the medical profession. For the Board, this was accomplished with the addition of public members. During the same legislative session that enacted the Open Meeting Law, the Medical Practice Act was altered and the Board was expanded from five to seven members. Five would be physicians, as in the past. The two additional members would be Nevada citizens not licensed to practice any healing art, not administering any health care facility, and without pecuniary interest in matters related to healing arts.[33]

Although there doesn't seem to have been open opposition to public members, there was initial skepticism on the part of physician Board members. Dr. Thomas Scully recalled that the physicians "didn't know what to expect from them or what their role

was . . . We sort of fumbled around, I guess is the best way to put it, for a while."[34] Public members were not quite sure of their duties, and some physicians were uncertain about the effectiveness of non-medical individuals in medical matters.

Eva Simmons was appointed to the Board in 1980. She had a background in education, both as a teacher and as a school administrator. She was not familiar with the Board before her appointment. At her first meeting she "thought the operation was peculiar . . . [laughter] There was no real agenda. I remember the men walking around the room, smoking their cigarettes, and just kind of conducting the business in a loosey-goosey fashion . . . The absence of structure is what really hit me."[35]

Mrs. Simmons believes that the Board has been careful to keep public health and safety the focus of its activity. It has effectively incorporated its public members: "They were always very open to the point of view of non-physician members, of public members . . . [and] careful to *ask* for an opinion from the public perspective as a public member saw it." And it is an opinion that the Board needs. Mrs. Simmons recalled one discussion about who would bear the cost of a monitor for a restricted physician. The physician response was, "The patient, of course." Mrs. Simmons had a different reaction:

> "Oh no! It's not the patient's fault that this other person has to be there to oversee." And, from that point on, anyway, the doctors discussed it, and the language became, "at no cost to the patient."

Involvement in the revision of the Medical Practice Act in 1985 was a process that Mrs. Simmons found both exciting and interesting. She is comfortable with the legal challenges to the law and the Board's authority:

> My belief would be that the law "has to gel." The law gels through legal challenges to the language of that law, or the application of that language to a given situation . . . I see the law increasing in its parity as the result of legal challenges . . . [it's] part of the process, and part of what is necessary.

Leo A. Wilner was a public member of the Board from 1985 until 1993. Retired from a career as executive director for synagogues in Los Angeles and Las Vegas, the work of the Board was familiar for him but its focus was "foreign." He found that, "you keep your mouth shut, and you do a lot of listening and learning . . . "[36] He perceived that the public might have doubts about physician oversight: "This would be like the fox watching the chicken coop, you know — doctors taking care of doctors; but it isn't so."

Mr. Wilner believed that the public belonged on the Board. One doesn't interfere in strictly medical matters, but one doesn't need medical knowledge to make a contribution to the process:

> But when it comes to levels of considering ethics, compassion, what? smoking drugs, taking drugs, alcoholism, substance abuse. That, you just need logic . . . When you're talking about ethics and compassion, everybody possesses that ability. You don't have to have any title.

Continuing Medical Education

Continuing Medical Education (CME) has been a divisive issue for physicians. In

1975 the Nevada State Medical Association sent a questionnaire to its membership regarding the requirement of Continuing Medical Education as a condition of licensure. Of the responses returned, 67 were in favor and 128 were not: physicians were not enthusiastic about compulsory continuing education in their field.[37] It was, however, something that the public viewed favorably because it bolstered the impression that physicians were keeping abreast of medical knowledge.

In spite of the disapproval, the Medical Practice Act as revised in 1979 "authorized the board of medical examiners to require compliance with certain continuing education requirements as a prerequisite to the renewal of a license to practice medicine."[38] The actual change to the law added a new section to Chapter 630 of NRS: "The board may require physicians who are licensed under this chapter to comply with continuing education requirements adopted by the board as a prerequisite to the renewal of their licenses." The key phrase was *may require* and the Board did not exercise its authority to require continuing education.

Dr. Anthony Carter was a member of the Board in the 1980s. He was against CME, believing that it put a burden on rural physicians. He was also unconvinced of the effectiveness of mandatory CME: "It is a major industry . . . I don't think it's ever been proven that requiring them to go to class makes them better [physicians]." In 1984 a legislative study of health care providers appraised the level of knowledge and skill required by licensing agencies, both when first licensed and during practice. The report of the legislative commission criticized the Board, noting that although it had the statutory authority it chose "not to adopt regulation mandating continuing education." The commission noted that eighteen states had such requirements, and legislation requiring continuing education was recommended.[39]

Dr. Carter remembers that it was "Senator Bill Raggio who informed the Board that he felt we should require CME, and it would be better for the Board to enact that legislation than for the state legislature [to do so]. Understanding his language, which was very clear, we enacted a CME requirement."[40]

Acting upon the statutory authority, which they had acquired in 1979, the Board added a requirement for forty hours of Category I CME during each biennial period. Opinion is still divided among physicians regarding the effectiveness of CME. A Carson City anesthesiologist views it as a waste of time and money for the most part, believing that the best forum for keeping up to date in a medical field is the hospital and work environment. It is in this arena that the reality of medical technology and procedure is tested, rather than the theory that seminars and articles offer, theory that might have little effectiveness or applicability in the everyday world of medical practice. In his opinion, mandatory Continuing Medical Education is a "feel good thing that accomplishes little, if anything."[41]

Umbrella Organization

One issue that is an occasional point of debate among politicians and medical practitioners is the idea of a combined medical board. A suggestion was made in 1971 that a "Healing Arts Board" be formed that would include medicine, dentistry, nursing, osteopathy, physical therapy, and "possibly even chiropractic." It was not received with favor by the Board. In 1987, members from the Nevada State Board of

Homeopathic Examiners approached the Board of Medical Examiners about "any positive feeling" regarding the possibility of combining the two boards. The Board of Medical Examiners rejected the suggestion, citing "basic ideological differences."[42]

It is not a favored topic for Board members to discuss, although it is possible that it will be the organization of the future. In some states — California and Virginia are two — a single medical board oversees the licensing and examination of a number of related health fields. In Virginia, there is an administrative governing board comprised of representatives from each health care board and public members. A 1989 report from a meeting of the Federation of Associations of Regulatory Boards indicated that the movement is "far from dead."[43]

The primary objection to a combined structure is money. The fees for allopathic physicians, $420 for a biennial registration in 1995, generate a significant income for the Board of Medical Examiners. The Board's budget comes from those fees and is not supplemented by state funds. Dr. Jacobs, and other physicians who expressed an opinion, maintain that doctors should control the money that they contribute. Control would be jeopardized if boards combined, and "Whoever the czar of that particular umbrella agency happens to be, will have control . . . because the person who handles the purse strings usually ends up dictating to that organization or board."[44]

Dr. Richard Grundy shares that negative view:

> I don't know as it's any advantage to combining them all. When I was on the Board, if we wanted information about some other board, we always got it, no problems at all . . . . So, if it ain't broke, why fix it? I get awful nervous. I've lived and worked in Carson City long enough to observe several empire builders at work [and] that's an ideal setup for an empire builder.

Physicians and Substance Abuse

An important issue for physicians and the public is substance abuse. A problem in the general population, the liability of chemical addiction is compounded for physicians dealing with life-and-death matters on a regular basis. Obviously, mistakes can prove fatal. The altered procedure for dealing with physicians and substance abuse is a significant change for the Board and an important part of their transition to a modern, professional organization.

In the past, the informality and small size of the Nevada medical community resulted in a somewhat offhand approach to physicians' abuse problems. The Board's 1966 discussion with a physician about "his current problems with narcotics" resulted in no disciplinary action. Board members felt the doctor had "gotten himself under control." Two years later, the Board ended discussion about another doctor, practicing in Eureka, with the following notation:

> The members of the Board recommended strongly [to the doctor] that he get control of his drinking problem and that if he feels the compulsion to over indulge he should get out of the community for a few days until he gets it out of his system; otherwise these complaints against him are going to continue and ultimately the Board will have to take action against him.

Problems with the Eureka physician continued. In 1975 the Narcotics Division of the Attorney General's office filed charges against the doctor, and in 1976 the Board filed charges of unprofessional conduct. The following year the physician voluntarily surrendered his license, issued in 1947, to the Board.[45]

The Board's relations with Dr. John Crear of Las Vegas, who underwent treatment for alcoholism, indicate a changing approach to substance abuse. Dr. Crear came to Las Vegas in 1966 at the urging of Dr. Charles I. West, the first black physician to practice in Nevada. It was a difficult situation for him. As the second black doctor he felt a great deal of pressure to perform correctly, to set a good example:

> I was working a lot of long hours — I was trying to do so good. I would get to work, and I would start drinking. I'd buy a small bottle of scotch, and I'd take a drink on the way down there . . . . Alcohol gets progressive. You want more and more.[46]

Dr. Crear began drinking more and more, but didn't realize he was an alcoholic. He had problems at work because he was "so slow." He was checking and double checking to avoid mistakes, and taking too long. His wife talked him into getting help. In 1973 he checked into the Hazelden Treatment Center in Minnesota. When he came to the attention of the Board, they requested that he come to a meeting:

> I had to go to Reno; they wanted to talk to me. I don't think they really knew what to do with me. In those days they didn't know what co-dependency was. It wasn't like it is now. Now they have the impaired physician program.

Dr. Crear continued treatment and reported his progress to the Board, which also received reports every three months from Dr. Crear's physician.

Relations between the Board and impaired physicians have progressed even more in recent years. Working with the Nevada State Medical Society, a program creating a Physician's Aid Committee has evolved. When a physician has a substance abuse problem, a team of physicians intervenes and assesses the situation. If the physician is willing and able to seek treatment, he or she enters into a contract with the Board. The type and length of treatment is specified, and the Board makes random, unannounced checks on the physician's progress. Urine tests can be required, also random and unannounced. If the terms of the contract are not fulfilled, the physician faces revocation of his or her medical license. Dr. Anthony Carter explained:

> We notify the clinic, "If Doctor X doesn't show up for his appointment or he drops out of your program, notify us immediately." We originally gave [the doctor] a punishment but suspended the punishment as long as [he] stayed in the program. If [he's] not in the program, [he's] out . . . and that could include loss of license . . . . That's pretty clear basic stuff, and I like that. You're given a chance, but you either comply or you're out.

In some cases immediate admittance to a treatment facility is required. Physicians have

had to simply lock the door of the office and leave for a treatment center. They have little choice in the matter if the Board and the Physician's Aid Committee determines prompt treatment is the best course. The Board has the authority to suspend a license on the spot. The program has been successful, and early intervention has helped a number of physicians. Dr. Carter believes that it is "ninety-nine percent [effective] if you get them early enough."

The issues that the Board of Medical Examiners have addressed, resolved, and, at times, resisted, have resulted in modification and growth for the Board. Those issues have emerged from changes in society, altered expectations by both patients and doctors, and, to a certain extent, challenges to the Board's authority. The modernization of the Board has been the result of a process, and the issues have contributed to the process. In the mid-1980s, however, the Board initiated change that reflected transformations in society and medical practice, with a complete revision of the Medical Practice Act.

Notes

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5

Modernizing the Board of Medical Examiners

The Medical Practice Act has been both amended and revised a number of times since the 1949 modification, as the Board and the legislature reacted to changing circumstances, public opinion, and, in some cases, special interest groups. Between the revisions of 1949 and 1985, there were a number of statutory changes — some minor, others more encompassing. The Nevada medical community and the legislature responded to local concerns as well as national mandates. With each change, the law became more specific regarding the Board's responsibilities and authority, as well as more complex.

More Fine-tuning, 1953-1983

The Medical Practice Act of 1949 provided for licensing of Canadian medical school graduates. In 1953 and 1955 that reference was expanded, and language clarified, to allow Canadian citizens who intended to become U.S. citizens to be licensed in Nevada. The issue of graduates of foreign medical schools was a matter of concern for the Board, as discussed below.

The Board of Medical Examiners was among a number of regulatory boards affected by a 1963 statute that changed the economic structure of the agencies by mandating audits and adherence to a fiscal year, and set salaries and travel expenses. Important for the Medical Board was authorization to employ attorneys and investigators — it had done so in the past, but this provided statutory authority.

The issue of licensing non-American or non-Canadian physicians was addressed by the 1969 legislature. The wording of the citizenship requirement was changed to allow for medical licensing of non-citizens who had "filed a petition for naturalization which is pending or, not having fulfilled the residence requirements for naturalization, has filed a declaration of intent to become a citizen."[1] This was the first time that Nevada law allowed for licensing and examination of non-American or non-Canadian citizens.

In 1971 the Board was affected by a change in the law that brought Nevada into compliance with federal immigration regulations. Rather than basing residency status for licensure on *intent* to become a U.S. citizen, the term in the statute was changed to require a candidate to be a *lawful permanent resident*.

The 1973 legislative session that recognized physician's assistants and brought them under the Board's aegis made extensive amendments to the Medical Practice Act. Sections were reworded and redefined. As an example, the phrase "habitual intemperance or excessive use of alcohol or alcoholic beverages or any controlled substance" became "practicing medicine when unable to do so with reasonable skill and safety to patients by reason of illness, excessive use of alcohol or alcoholic beverages or any controlled substance . . . or any mental or physical condition." Changes were generally clarifications rather than augmentations of the Board's function. Rebates or compensation for referrals were defined as unprofessional conduct, but the law accommodated division of fees in partnerships and medical corporations.[2]

As had happened in a previous session, the Board was again affected by the need for the state to comply with federal law. In this case United States Supreme Court decisions of *Roe v. Wade* and *Doe v. Bolton* forced a change in one of the components defining unprofessional conduct. As mentioned in a previous chapter, abortion had been criminalized in Nevada in 1877. In 1973, "procuring, or aiding or abetting in procuring, criminal abortion," was changed to "performing, assisting, or advising in unlawful abortion." The criteria for lawful abortion were detailed in another chapter of the Nevada Revised Statutes.[3]

In addition to the impact of the Open Meeting Law and the augmentation of the Board with public members, legislation in 1977 altered the procedure for disciplining physicians. The amended Medical Practice Act began with the legislature's declaration that "the medical profession is accorded the widest scope of practice, deemed to possess the highest skills and therefore charged with the greatest responsibility." Consequently, the lawmakers pronounced, "the public health and welfare demand for the medical profession the highest and most effective means of review and discipline . . . "[4]

To that end, the procedure for enforcing the disciplinary aspect of the Medical Practice Act was stipulated. The definition of unprofessional conduct was rewritten, and the process for investigating and disciplining physicians charged with violating the law was specified. It was a six-page addition to the law that indicated the procedures for filing charges, setting hearing dates, the use of witnesses, and the Board's subpoena power. The law also enumerated punitive action the Board could impose on a physician guilty of misconduct.

The 1977 change was a significant advancement in the Board's modification of its role in medical oversight. Nevada was growing rapidly, and medical practice adjusted to the resultant increased complexity of life in the Silver State. The Board of Medical Examiners was working to keep in step with the changing times, and the 1977 modification of the law was a precursor to a complete revision in 1985.

In 1983 the legislature again amended the Medical Practice Act, with more specifics relating to unprofessional conduct and physician discipline. But the piecemeal changes had resulted in a piecemeal statute. There was a need for reexamination of the entire Medical Practice Act; that was done in 1984. This resulted in sweeping change — a

revision that was carefully planned, studied, and implemented. The 1985 Medical Practice Act put Nevada in the forefront of medical licensing legislation.[5]

Revision of the Medical Practice Act, 1985

To advise them as they revised the Medical Practice Act, in 1984, the Board conferred with attorneys and a consultant from Washington, D.C. Oregon had one of the most progressive medical practice statutes at that time, and it served as a pattern for Nevada. What resulted was a model act that integrated national trends in physician education, licensing and oversight, participation by public members, open meeting laws, license requirements, and physician discipline.[6]

The Medical Practice Act in effect in the late twentieth century is a much more precise and extensive document than that first effort in 1905. The law had responded to challenges to the Board's authority by specifying procedure and limits, both in a piecemeal fashion and with major overhauls. The 1985 revision was a major overhaul. The three most important results of the new law dealt with complaint investigation, physician discipline, and the postgraduate training requirement.

Investigation and the Investigative Committee

The investigative function of the Board of Medical Examiners has two aspects: first, the certification of the initial documents presented by a physician to acquire a license. Second, investigation of complaints lodged against physicians for malpractice or misconduct. Charges made against a physician are a serious matter and cannot be accepted at face value. The Board investigates physicians before either dismissing charges or proceeding with hearings and discipline.

The investigative process is complicated, and can be lengthy and expensive. As with other Board functions it has become more complex over time; but even in the early days, investigation of charges against a physician could be time-consuming and result in unexpected developments. An interesting example of this complexity occurred in the late 1920s.

In August, 1927, a man representing himself as Dr. Arnell Boyd Cheatham applied for a license examination in Nevada.[7] He indicated on his application that he was a 1907 graduate of Memphis Hospital Medical College and presented to the Board a certificate in lieu of a diploma, which had been lost. His certificate of moral character was signed by a single Reno doctor (two were required), who had known Dr. Cheatham for one year. Dr. Cheatham passed his written exams with a cumulative score of 80 percent, comfortably above the minimum requirement of 75 percent.

The following year, Dr. Cheatham "had some trouble with one of the members of the Washoe County Medical Society." When he applied for membership in the medical society, background checks revealed inconsistencies. Dr. Cheatham had not been employed by the U.S. Public Health Service, as he had indicated; the position that he held at Stanford University was not quite what he had claimed; and he had not been registered as a physician in California. Neither McGill University in Montreal, nor Peking Union Medical College in Peking, China, had any record of Dr. Cheatham's registration.

The Board launched its own investigation of Dr. Cheatham, stung by the county medical society's implication that it had

been lax in its licensing procedure. In one letter Dr. Thomas Bath, secretary-treasurer of the county society, informed Dr. Edward Hamer, secretary-treasurer of the Nevada Board of Medical Examiners, that he thought Dr. Cheatham was a "fake," and indicated that, "Hereafter, I am going to urge that this society SEE and VERIFY the certificates of all applicants." In his correspondence with the secretary of the California Board of Medical Examiners, Dr. Hamer displayed his pique when he mentioned that Dr. Bath's letter had "caused quite a stir in this office." He continued: "He was informed of course that under no conditions would this Board allow the County Society to dictate to them." Dr. Hamer had been equally direct with Dr. Bath:

> The attitude that you assume regarding your insistence that the society SEE and VERIFY the certificates of all applicants is preposterous. Allow me to say to you Doctor Bath, that this Board is capable of attending to its own affairs without any help from the Secretary of the Washoe County Medical Society. It has its laws under which it operates, and if you are not satisfied with these laws, please get busy and help us correct them so that we can operate more satisfactory [sic] to the profession at large. Personally, I resent your last paragraph in your letter . . . [and while] I have the highest regard for the Washoe County Medical Society . . . do not for an instant think that we will allow that Society to control the Board of Medical Examiners.

As the investigation by the Board and the county medical society, who worked together in spite of their disagreement, progressed, the story began to unfold. The Navy Department revealed that they had records for A. B. Cheatham, who had been discharged with a clear record. They also had records for Samuel Arnell Cheatham, a hospital apprentice, who had been "discharged as undesirable." Suspicions about Dr. Cheatham had been prompted, in part, by his nickname, "Sam," and a belt buckle that he wore with the initial "S."

Dr. Bath had heard of a "covert" statement by Dr. Cheatham that he had killed a man in a quarrel after his return from the navy, but was freed. Bath's inquiries to officials in the Texas county where A. B. Cheatham was located disclosed no such situation involving that individual.

An additional complication in Dr. Cheatham's story was his claim that his diploma had been washed overboard when the ship he was aboard as a medical officer ran aground off the coast of China in 1926. The steamship line confirmed that the ship had a medical officer by that name and that his diploma would have been on board the ship when it was grounded. Dr. Bath, who had also served as a ship's medical officer, claimed that he could not understand how such a thing could have happened.

The investigation of A. B. Cheatham led to Millersview, Texas. A physician named Anner Bert Cheatham, known by his initials of A. B., was in practice there. The Board requested a photograph of Dr. Cheatham. He refused to have a picture taken, as it was "32 miles to a photoman." He wanted to help locate the crook, but indicated he was "through with the matter," warning: "Don't try to scare me. I have been here to [sic] long and had to work to [sic] hard for my M. D. license." The Reno physicians were suspicious of his reticence, believing that he was "concealing this fellow." They deduced, but never proved,

that the Cheathams were brothers, with one protecting the other.

The Nevada "doctor" doesn't appear to have harmed anyone during his practice; on the contrary, he saved one woman's life. Picnicking at Pyramid Lake, one member of Dr. Cheatham's party was bitten on the arm by a snake, "a little rattler of the side-winder variety." Dr. Cheatham cauterized the wound and brought the victim back to Reno, where he administered snake-bite serum.[8] The suspect Dr. Cheatham practiced medicine in Reno for about four months, then moved on to San Francisco.

Working with the California State Medical Board, Nevada continued the investigation. Because of Dr. Cheatham's claim that he had been involved in a murder, Dr. Hamer wrote to penal institutions. He found that a Samuel Cheatham had served ten years in the Missouri State Penitentiary for first degree murder. He had worked as a nurse while in prison. Photographs sent by the prison confirmed that the Dr. A. B. Cheatham practicing medicine in Reno was indeed Samuel Cheatham. Cheatham's murder case had been the basis for an article in a 1929 issue of *Great Detective Cases*.

Dr. Cheatham, who was in San Francisco at the time, had written to the Board when the investigation was initiated: "I have just learned, through a visitor from Reno, that my license to practice medicine in the State of Nevada has been revoked." Demanding an explanation, Dr. Cheatham warned the Board that he was sending a carbon copy of his letter to an individual named Johnny Mueller,"[9] and the chances are that he will get in touch with you shortly in regards to this matter." Dr. Hamer's reply was terse. He assured the physician that no charges had yet been filed and that he would be given an opportunity to respond if they were. Dr. Cheatham was duly notified, but did not reply. The Nevada medical license granted to A. B. Cheatham was revoked by the Board on August 9, 1929.

The investigation of Dr. Cheatham lasted more than a year and involved inquiries to a number of federal and state agencies, as well as foreign and domestic medical schools. It also strained the budget of the Board and prompted a request for a statute change to generate additional funds, raised by a license tax.[10]

Dr. Cheatham's case was resurrected in 1939 when the Nevada Board once again cooperated with the California medical board by sending their agent a photograph of Samuel Cheatham. California medical officials were investigating a "C. S. Cheatham, who in age and description resembles Samuel A. Cheatham, alias A. B. Cheatham." The man located in San Diego, California, was not the same individual.

One incident involving a Las Vegas physician and forged credentials underscored the difficulty of checking documents. In 1975, Dr. Rando Grillot received a medical license in Nevada. He had presented a copy of a Mexican medical school diploma, verified by the U. S. Consulate's Office in Mexico City, to the Board. The Educational Council of Foreign Medical School Graduates accepted the diploma. Grillot had also recently passed the FLEX, a national exam for graduates of foreign medical schools. He practiced emergency room medicine in Las Vegas, and established Emergency Medical Services, Inc., which contracted to provide emergency room services at Southern Nevada Memorial Hospital.[11]

Dr. Grillot was well known in Las Vegas. He told friends that he had financed his undergraduate education at Tulane by playing the clarinet, and had worked with Bing Crosby, Phil Harris, and Jack Benny. He kept

up his musical involvement in Las Vegas, playing with a band on Sunday nights at the Royal Inn Casino.[12]

The quality of Dr. Grillot's medical care was never questioned; it was the legitimacy of his credentials that was in doubt. A group of Las Vegas physicians contacted the Nevada Attorney General's Office, which requested that the Board investigate. The Board's attorney and an investigator traveled to Mexico City and found that the diploma was a forgery. In a meeting with the Board, Grillot admitted that he had been a medical corpsman during World War II, but had never gone to medical school. He had purchased his forged diploma in the Los Angeles area.[13] He surrendered his license to the Board before the scheduled hearing date.

There was public support for Grillot, expressed in letters to Las Vegas newspapers. He was described as "a great human being, a humanitarian." An article a month later indicated that Dr. Grillot was planning, "to initiate some kind of action to vindicate his reputation," but there is no record of further action. Implications were made in the press that the investigation of Dr. Grillot's credentials was politically motivated. Grillot's supporters charged that the physicians who brought Grillot to the attention of the attorney general's office had unsuccessfully competed with Grillot's medical group for the emergency room contract at Southern Nevada Memorial Hospital. Regardless of the motivation for charges, the Medical Practice Act was specific regarding the procedure for the case. If the charge had been frivolous, the Board would not have continued the investigation. If there had been no wrongdoing the proceedings would have remained confidential. Grillot, however, had violated the law and was guilty of "professional misconduct," because he had "willfully and intentionally" submitted a "forged or false document in applying for a license to practice medicine."[14]

Recent computer technology has simplified the process of credential verification and slowed the stream of letter writing and telephone calls that were the methods of checking in the past. The Board no longer accepts documents presented by the physician. They require original documents directly from the medical schools and the residency programs, a stipulation prompted, in part, by the incident with Grillot. Identification is further validated with photographs that are required with application and remain in the physician's files.

One of the major components of the 1985 Medical Practice Act revision was the creation of an investigative committee as part of the structure of the Board of Medical Examiners. Investigation of a physician, as indicated by Dr. Hamer's involvement in the Cheatham case, had been conducted by the secretary-treasurer of the Board. It was a tremendous burden and responsibility, one that had become more difficult as the size of the medical community expanded.

Dr. Thomas Scully, who became secretary-treasurer of the Board when longtime member Ken Maclean retired, found the investigative responsibilities of the job almost overwhelming when he took over in 1983. He concluded: "This is an impossible task for one person; no one person has the breadth of knowledge." He also believed that it was difficult to remain objective, with "all sorts of opportunities for conflict of interest." The investigative process was an important impetus for the 1985 revision.

Responsibility for investigation of complaints was transferred from the secretary of the Board to the Board, "or a committee of its members." The committee that the Board set up was comprised of two physicians

— one of them the secretary of the Board, who acted as chair, and one public member. The investigative committee (IC) members reviewed complaints against physicians and made a recommendation for appropriate action to the Board. There was also provision for a hearing panel that would conduct hearings and make recommendations to the Board. All of the changes resulted in the involvement of more people in the process, and they were intended to provide a fairer, more efficient consideration of complaints against physicians.

A 1991 clarification of the investigative committee function formally separated the investigation by the committee and *review* by the Board. The members of the IC do not participate in any hearings or action by the Board once they have completed their investigation and presented their recommendation to the Board. The number of members on the IC was expanded by the Board in 1991, from three to four. This change was based on the belief that if the evidence is sufficient to convince three of the four IC members, there is a strong case for wrongdoing. Dr. Thomas Scully notes that "usually, if there's sufficient doubt in the mind of any committee member, there's sufficient doubt in several committee members' minds, and nothing goes forward."[15] The size of the Board was increased in 1985, from seven to nine members, so there are enough Board members outside of the IC to conduct reviews of forwarded cases. Most importantly, an unbiased perspective is maintained for the Board members who participate in hearings for accused physicians.

Physician Discipline

The disciplining of physicians is an additional aspect of the Board's function that has become more complex over time. The Board has always had the authority to revoke a license for unprofessional or dishonorable conduct. And physicians have always had the right to appeal the Board's decisions to the courts. Over time, the law has been expanded to clarify what constitutes physician wrongdoing and the process for appeal through the courts.

Increasing concern over public safety because of impaired physicians influenced changes in physician discipline in the 1985 revision. Where the law had previously given the Board authority to impose "terms, provisions or conditions as the board deems proper," the revised statute was more specific. It gave the Board the specific authority to require the physician to participate in alcohol or drug treatment programs, as well to as require supervision of medical practice, impose community service time, or insist on additional training or education. As noted in the previous chapter, the problem of the impaired physician has been a matter of public anxiety. The 1985 Medical Practice Act targeted those concerns and incorporated solutions.

One procedure for physician discipline that was eliminated in 1985 was the process for private reprimand. In light of public demands for more open discourse with regulatory boards, and concerns about impaired physicians, the Board maintained that such disciplinary recourse was not in the public interest, and that option was removed.

Postgraduate Training

An important factor in reestablishing the status of medicine in the late nineteenth and early twentieth centuries was the reform of medical education and training. The requirements for a medical degree have

expanded over the twentieth century, and physician training has been lengthened. Stipulations for licensure under Nevada's medical statutes have reflected that change.

The 1905 Medical Practice Act required that an individual applying for a license present a diploma from "some legally chartered medical school" that had requirements "in no particular less than those prescribed by the Association of American Medical Colleges." By 1949 the diploma had to be accompanied by proof that the applicant had completed at least one year of intern training in a program recognized by the AMA. The system of hospital internships had emerged along with the development of modern hospitals and reformed medical education. Approximately three-quarters of medical school graduates were taking internships by 1912.[16]

The increasing complexity of medical knowledge affected medical training over the twentieth century. Johns Hopkins Medical School built a hospital along with the medical school, and the system of advanced training in specialized fields was established there. The term "residency" was first used at Johns Hopkins, and the development of extended teaching in the hospital setting contributed to a lengthening of medical training. As had happened with internships, as the programs developed, medical graduates found it increasingly necessary to participate in residency programs and postgraduate training.[17]

By 1985, almost all medical school graduates, 94 percent, were obtaining a minimum of three years postgraduate training. The Board's spokesman, Dr. Thomas Scully, maintained that, with the need for an increased depth and breadth of medical knowledge, one year of postgraduate work was inadequate preparation for practice. 80 percent of the physicians licensed in Nevada in 1985 had three years postgraduate training.[18]

In addition, a discrepancy had developed in requirements for a medical license. Prior to 1985, foreign medical school graduates were required to have had three years of postgraduate training, with one year in an American or Canadian program. American medical school graduates were required to have had only one year of postgraduate training. Such a requirement was discriminatory and needed correction.

The most significant argument for a change in educational requirements for licensure, however, was that of public health and safety. Speaking to Senate and Assembly committees, Dr. Scully successfully argued that physician quality and competence were the important issues. A requirement for three years of postgraduate medical training recognized the altered trends in medical education while fulfilling the Board's responsibility to protect the public.

The 1985 revision of the Medical Practice Act both incorporated changes that had been made over the years and made innovations in physician licensing and discipline. It was a successful melding of the past and the future: using what worked and discarding what didn't, while adapting to the needs of a changing profession. It has not been the final alteration of the Medical Practice Act; there have been minor changes since that revision. It will undoubtedly not be the final revision of medical legislation — adaptation on the part of the Board and the legislature has been both necessary and attainable in the near century since the Board's creation.

The Examination: Evolution of Exams — Local to National

One of the primary functions of the Board from its inception has been to determine the competency of candidates for a medical

license in Nevada through examination, both written and oral. As noted earlier, the first Board was directed to conduct "thorough and searching" exams, a mandate that the Board has continued to attempt to fulfill. Written examinations have covered a wide spectrum, and the oral exam, discussed below, has been used to judge both knowledge and character.

As with other aspects of the Board's function, however, the examination process has become more complicated. In early decades applicants were tested directly by the Board, and a score of 75 percent was passing. Dr. Thomas Hood, who was licensed in the mid-1940s, thought his exam was difficult:

> There were, oh, I think eleven of us, and we had to spend two days. We came to Reno and they gave us a written test and it was kind of tough . . . The one I had trouble with was dermatology. I had very little dermatology, and they had some real tough questions on that. [laughter][19]

Difficulties with examinations were a problem that many licensing boards struggled with, and a series of national examinations were developed to provide a solution. In 1883, the former president of the AMA called for licensing examinations by state boards. By 1915, the National Board of Medical Examiners was established to elevate standards for qualification for practice and to facilitate recognition of qualification.[20]

The national examinations were aimed at establishing uniform standards for medical school graduates. Those examinations have changed to meet the needs of licensing agencies throughout the country, in addition to special needs for examining and licensing foreign medical school graduates. The Nevada Medical Board has kept pace with those changes and has recognized and accepted the different examinations over time.

The most recent change has been the implementation of the United States Medical Licensing Exam (USMLE). Similar to the Federation Licensing Examination (FLEX) that preceded it, the USMLE is given in three parts. Typically, a medical student takes the first section in the second or third year of medical school; another section is administered just before graduation; and the final segment in the first or second year of postgraduate training. The sections of the exam consist of about five hundred questions that are given over a two-day period.[21] That battery of 1500 questions provides a uniform examination of the medical student's breadth of knowledge, and it gives medical licensing boards an accurate assessment of an applicant's achievement in medicine.

The difficulties of administering exams, which could differ widely by state, have been simplified. The Board also has the option of examining an applicant in an oral examination if there is any doubt about an applicant's ability. If a physician has lost his or her license for misconduct, the Board can examine him or her for medical competency. The Board has kept current with national trends in medical examination, while keeping local control over licensees.

Foreign Medical School Graduates

The issue of licensing graduates of foreign medical schools has been a dilemma for the Board for decades. The 1905 Medical Practice Act required that diplomas presented to the Board be from a school meeting the criteria of the Association of American Medical Colleges and specified that examinations be administered in the English language. Non-citizens, however, were not specifically

excluded. A 1931 change in medical statutes added the requirement of U.S. citizenship or intent to gain citizenship.

In a 1933 resolution, the Board of Medical Examiners clarified their position regarding graduates of foreign medical schools. Their statement supported the requirement that individuals, citizen or non-citizen who had matriculated from European medical schools, applying to be examined by the National Board of Medical Examiners, demonstrate evidence of pre-medical education that was equivalent to requirements of American schools. This was a response to national concern over the influx of physicians fleeing Europe and the rise of authoritarian dictatorships, particularly Hitler and the Nazis. European doctors were often unwelcome competition to a profession that had been working for decades to increase status and income by reducing their numbers. Tightened strictures were evident in a sharp increase over the 1930s in the numbers of foreign doctors who failed medical licensing examinations.[22]

In the 1950s there was another influx of foreign medical school graduates. The internship and residency programs that had developed required large numbers of physicians to serve as house staff. Twelve thousand such positions were available in 1957, but American medical schools were only graduating about 7,000 physicians a year. Hospitals turned to medical schools overseas to provide an important, and relatively inexpensive, labor source for rapidly expanding and developing hospitals. Over the decade of the 1950s, the percentage of foreign medical school graduates that comprised house staffs in hospitals increased from 10 percent to 26 percent.[23]

Nevada's alteration of the Medical Practice Act over the 1960s, 1970s, and 1980s reflects the changing physician population. The issue of the quality of medical education had been problematic for American schools, and was even more so for overseas schools. Members of the Board acknowledged that a superior medical education could be obtained in foreign schools, but that inferior schools also existed. Obtaining proof of legitimate credentials, as had happened with the Grillot incident, could be difficult. In addition, availability of medical school transcripts could change with the political climate.

The Passing of the Oral Exam

The oral exam was a part of the original statute creating the Board, and it provided an opportunity for the Board members to come face-to-face with their new colleagues. The exam could be a grueling experience, particularly if there was doubt about a candidate's ability. It could be pro forma if the candidate was known to the Board. Dr. Leslie Moren applied for a license in 1938 and traveled to the Board meeting with Dr. Roantree, who was on the Board at the time. At the oral examination, he remembers another Board member telling him: "'If you're going with Dr. Roantree, that's good enough, here's your license.' They felt I'd been screened by Dr. Roantree enough, in effect."[24]

Dr. Richard Grundy had worked in Nevada as a sales representative before he returned to college for a medical degree. He came back to Nevada to go into practice with physicians he had met in his travels. He took the oral exam in 1959, an experience he recalls clearly:

> I was supposed to be at the Riverside Hotel in Reno at ten o'clock in the morning. I sat outside the door all day long. About six or seven o'clock they called me in and asked some sort

> of question about how to treat snake bite. I told them and they just sort of all congratulated me and said, "OK, you passed."

Dr. Grundy realized that they had his records and the recommendation of previous Board members, but it was an informal style: "Everything was sort of done in an easygoing manner then. But I would argue with somebody if they said it was lax or not thorough enough. Maybe they didn't write it all down, but they knew what they were doing."[25]

Dr. Ted Jacobs and his wife, Dr. Parvin Modaber were questioned in some detail for their oral exams in 1963. Both were internists and their exams were the equivalent of curbside consultations: "They wanted to know what to do with some patients' problems. Since they had specialists in internal medicine, they took advantage of the situation. We gave them free consultations."[26]

As medicine became more specialized, the Board required the assistance of specialist physicians to help in testing applicants' knowledge in their specialty. That presented problems in one particular case when two specialists in internal medicine declined to pass an applicant. As Dr. Jacobs recalled:

> We looked into his file and we found out that he had just passed the American Board of Internal Medicine examinations a few months previously, which are very difficult exams. It made it very difficult for us then to go to the applicant and say, "Listen, we know you passed the American Board exams just a few months ago, and now we in Nevada don't think we can pass you." He'd say, "What's the matter with you? You crazy?"[27]

The inconsistency of such a response presented a possible legal complication for the Board. The Board changed its procedure and began giving an objective examination that was similar for all applicants. When it analyzed test results, it realized that nobody was failing. The oral exam didn't seem to be especially difficult, particularly effective, or even necessary. The credentialing process had become so effective that an oral examination was superfluous.[28] It could also present a financial burden, requiring a trip to Reno or Las Vegas for a board meeting.

In addition, by the late 1980s the number of candidates applying for licensure in Nevada had increased to the extent that it was burdensome to administer an oral examination to all applicants. The oral examination was less a test of an applicant's knowledge than an opportunity to meet with a physician who would soon be a colleague.

The Board had the statutory authority to determine what type of exam it would administer, thus there was no legal requirement for an oral examination. In 1995, the Board eliminated the oral examination for medical license applicants.

To a certain extent, the passing of the oral examination marked the end of an era. Nevada medical oversight had moved beyond the informal structure of an earlier period, when the medical community was small and physicians known to one another. It was one more step, one among many, in the process of professionalization of the Board.

If it were possible for S.L. Lee to attend a Board of Medical Examiners meeting in 1996, almost a hundred years after his own experience on the Board, he would find little around him familiar. Beyond the obvious differences of dress, surroundings, and communications devices, the late-twentieth century Board is very unlike the

late-nineteenth century Board. The *intent* is the same: physician licensure and oversight in order to protect the health and safety of the citizens of Nevada. The means, however, of accomplishing that goal, as the preceding chapters have related, have altered drastically over the century.

That drastic alteration has been a response to significant change in the social, political, and economic structure of Nevada. Demographic change in Nevada has radically modified the landscape and the populace of Nevada. There are still mining towns, small towns, and wide open spaces, but Dr. Lee would find it impossible to be personally acquainted with the majority of the physicians in the state. The decline in Nevada's population that was reflected in the 1900 census has been reversed. There has been a phenomenal population increase almost a century later. The medical needs of a growing population and the increase in the number of physicians needed to meet those needs have required change in the law and the Board's function. The necessary changes have been made.

Medicine and the practice of medicine have become more complex, necessitating almost constant accommodation and adjustment on the part of the Board of Medical Examiners. Again, the purpose of the Board is essentially the same, but the operation of the Board has become more complicated, as well as more public. The days when five physicians could informally sit down together and discuss possible solutions to a colleague's drinking problem are long past. Public demands for accountability on the part of elected and appointed officials have opened much of the Board's activity to public scrutiny and involvement. The Board has acted to protect both the public and its right to information, while preserving the physician's right to privacy. An increasingly litigious society has further complicated physician oversight and increased the complexity of the Board's work.

Nevada has been a part of, yet somewhat unique within, America's history of medicine and medical licensure. In general, Nevada's Medical Board has followed national trends in its response to the need for medical oversight. In 1985, however, the Board set an example with its revision of Nevada's Medical Practice Act. Relations between allopathic and sectarian medicine in Nevada have been both reflective of and distinct from national positions.

The response to population growth, political, economic, and social change, as well as medical complexity has been a process of modernization. It has been a continuation of the search for "some of the wisest and gravest" to advise "Chirugeons and Physitians" that began in mid-seventeenth century Massachusetts. It has been an undertaking that has extended over time and across territory, and one that will continue into the second century of the Nevada State Board of Medical Examiners.

Notes

1. *Statutes of Nevada*, 55th sess. (Carson City: State Printing Office, 1969), 210.

2. *Nevada Statutes*, 57th sess., vol. 1 (Carson City: State Printing Office, 1973), 503-520.

3. Ibid., 1637-1640.

4. *Nevada Statutes*, 59th sess. (State Printing Office: Carson City, 1977), 820-828.

5. The 1985 revision of the Medical Practice Act is discussed in some detail in the oral histories of Larry Lessly and Dr. Thomas Scully, in volume two of this history.

6. Scully interview.

7. Arnell B. Cheatham file, Nevada State Board of Medical Examiners' office, Reno, Nev.

8. *Reno Evening Gazette*, 5 October 1928.

9. John Mueller was an assistant state engineer. He became an associate of Norman Biltz and part of the McCarran political machine. He was an influential lobbyist and power-broker in Nevada politics in the 1930s, 1940s, and 1950s. See Jerome Edwards, *Pat McCarran, Political Boss of Nevada* (Reno: University of Nevada Press, 1982), and C. Elizabeth Raymond, *George Wingfield: Owner and Operator of Nevada* (Reno: University of Nevada Press, 1992).

10. An amendment in 1929 added a two dollar tax, paid annually, to each medical license issued by the Board.

11. Arturo Rando Grillot file, Nevada State Board of Medical Examiners' office, Reno, Nev.

12. *Las Vegas Sun*, 30 June 1979; 11 June 1979.

13. Scully interview.

14. *Nevada Statutes*, 1977, 415.

15. Scully interview.

16. Starr, 124.

17. Ibid., 116.

18. Notes from Dr. Thomas Scully, testimony to Nevada Legislature for 1985 revision of Medical Practice Act.

19. Hood interview.

20. See John P. Hubbard and Edithe J. Levit, *The National Board of Medical Examiners: The First Seventy Years* (Philadelphia: National Board of Medical Examiners, 1985).

21. Scully interview.

22. Starr, 272.

23. Starr, 360.

24. Moren interview.

25. Grundy interview.

26. Jacobs interview.

27. Jacobs interview.

28. Scully interview.

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Appendix A: Members, Nevada State Board of Medical Examiners, 1899-1995

Members, Nevada State Board of Medical Examiners 1899-1995

Original Board Members, 1899:

Guinan, J.	Carson City
Lee, S.L. 1899-1903, 1905-1907, 1913-1916	Carson City
Phillips, P.T. 1899-1902	Reno
Fee, George 1899-1901	Reno
Wagner, Philopena 1899-1905	Carson City

Subsequent appointments, reappointments:

Hood, W.H. 1900-1904	Battle Mountain
Samuels, W.L. 1901-1905	Winnemucca
Garner, J.L. 1905-1909	Tonopah
Circe, W.J. 1905-1906, 1908-1912	Carson City
Lewis, J.A. 1905-1906, 1910-1917	Reno
Gardner, G.M. 1905-1909, 1919-1923	Fallon
Sullivan, J.J. 1906-1908, 1910-1914	Virginia City
Richardson, R.H. 1910-1913	Ely
Wheeler, E.A. 1913-1917	Goldfield
Morrison, S.K. 1913-1922	Reno

Mangan, P.J. 1914-1919	Winnemucca
Grigsby, E.S. 1915-1919	Tonopah
Gibson, S.C. 1917-1919	Reno
Olmstead, A.C. 1919-1921, 1923-1927	Wells
Edwards, W.M. 1919-1923	Mason
DaCosta, A.R. 1922	Reno
Robinson, J.L. 1926-1930	Reno
Shaw, W.A. 1926-1932	Elko
Muller, V.H. 1926-1928	Reno
Hamer, H.H. 1927-1935	Carson City
Howell, W.L. 1927-1938	Gardnerville
Creveling, E.A. 1927-1935, 1945-1948	Reno
Brown, H.J. 1928-1937	Reno
Roantree, R.P. 1932-1953	Elko
Worden, J.E. 1936-1940	Fallon
Bowdle, R.A. 1938-1946	East Ely
West, C.W. 1939-1945	Reno
Magee, G.R. 1939-1943	Yerington
Cantlon, V. 1939-1943	Reno
Anderson, F.M. 1940-1942	Carson City
Petty, R.A. 1942-1943, 1960-1969	Carson City
Ross, G.H. 1943-1961	Carson City
Balcom, R.D. 1943-1946	Las Vegas
Hovenden, O. 1944-1948	McGill
Slavin, H.B. 1946-1951	Las Vegas
Frolich, W.H. 1949-1953	East Ely
Maclean, K. 1949-1979	Reno
Moren, L.A. 1950-1977	Elko
Eklund, R.N. 1951-1955	Las Vegas
Ross, T.V. 1953-1961	East Ely
Collette, G.A. 1953-1954	Elko
Hardy, S.L. 1955-1967	Las Vegas
Anderson, R.J. 1965-1971	East Ely
Turner, K.E. 1967-1971	Las Vegas
Grundy, R.D. 1969-1980	Carson City
Zucker, R. 1971-1975	Las Vegas
Cammack, K.V. 1971-1977	Las Vegas
Jacobs, T. 1975-1995	Las Vegas

Kaye, H. 1977-1980	Carson City*
Crockett, I.M. 1977-1980	Las Vegas*
Christensen, G.N. 1977-1981	Ely
Scully, T.J. 1977-1985, 1988-1996	Reno†
Prior, E. 1980-1984	Reno*
Carter, A.J. 1980-1988	Las Vegas
Simmons, E.G. 1980-1994	Las Vegas*
Baker, R.H. 1981-1989	Las Vegas
Clift, R. 1983-1987	Reno
Ebner, K.L. 1984-1996	Reno*†
Avery, M.R. 1985-1993	Reno
Khan, I.U. 1985-1993	Las Vegas
Wilner, L.A. 1985-1993	Las Vegas*
Snider, D.E. 1987-1992	Carson City
Nagy, M.N. 1989-1997	Las Vegas†
Baggett, R.T. 1992-1999	Carson City†
Buchwald, S.S. 1993-	Reno
Countess, J.D. 1993	Las Vegas*
Desai, D.K. 1993-	Las Vegas
Rosencrantz, A.D. 1993-	Las Vegas*
Scaramosino, V. 1994-	Las Vegas*
Stewart, P.A. 1995-	Las Vegas

* Public members.

† Scheduled end of term.

Appendix B: First Examination Administered by the Board of Medical Examiners, 1899-1900

First Examination Administered by the Board of Medical Examiners, 1899-1900

Surgery and Pathology

1. Describe inflammatory action.
2. What is a compound comminuted fracture?
3. How would you treat a simple fracture of the femur at its central portion?
4. How would you treat septicemia locally and constitutionally?
5. Give differential diagnosis of hernia, hydrocele and varicocele.
6. Classify carcinomatæ.
7. What is meant by term "infection," as used in a surgical sense?
8. Describe Potts' fracture.

Physiology

1. Describe briefly the circulation of the blood.
2. What are the functions of the lymphatic glands?
3. Give the reaction of normal urine.
4. Describe the physiological process involved in the healing of a wound by granulation.
5. What classes of food are digested in the stomach alone?

Chemistry and Toxicology

1. Give chemical formula for water, nitric acid and common salt.
2. Give chemical reaction of elixir of vitriol.
3. Name some of the medicinal substances that should not be placed in the same mixture with fluid extracts.
4. What are the antidotes for carbolic acid, bichloride of mercury, morphine, alcohol and ergot?
5. What is hydrogen peroxide and in what percentage of dilution is it ordinarily used?

Eye, Ear, Nose and Throat

1. How would you treat a simple acute conjunctivitis?
2. How would you treat acute otitis media suppurative?
3. How would you plug the nasal cavity anteriorly and posteriorly for nasal hemorrhage?
4. How would you treat laryngitis in the adult.
5. How would you treat globus hystericus?

Therapeutics

1. What is meant by therapeutical indication?
2. Give physiological actions of digitalis, uses and dose of the tincture.
3. Write a prescription for the cough in acute bronchitis.
4. Give dose of tincture nucis vomicæ, sulphate of strychnia, arsenite of strychnia, codeine, ipecac et opii pulvis.
5. Write a prescription containing chloride of iron, dilute phosphoric acid, strychnia sulphate, glycerine and syrup of orange peel; give dose, and in what conditions it would be useful?

Hygiene

1. What is hygiene?
2. What elements are necessary to retain good health?
3. What should the conditions of our houses be?
4. What precautions in regard to contagious diseases?

Diseases of Children

1. Describe the fœtal circulation.
2. What is rachitis and what its pathology?
3. What are the complications, sequelæ, prophylaxis and treatment of scarlatina?
4. What are the symptoms, sequelæ and treatment of measles?
5. What is the difference between measles and roseola?

Gynecology

1. Describe the discharges of the female genitalia, their sources, appearance and properties.
2. What is anti-flexion?
3. How would you make the diagnosis of a tumor by palpation?
4. What is amenorrhœa, pathological and physiological?
5. What is dysmenorrhœa? What are the varieties?

Theory and Practice of Medicine

1. Define general medical pathology.
2. What is histology? Of what does it treat?
3. What is meant by fatty degeneration of the heart? What changes take place?
4. What is leucocythæmia?
5. What are the zymotic diseases?
6. What are the eruptions of smallpox called in their various changes, from their first appearance to the stage of suppuration?
7. Diagnose lead colic.
8. What is gastralgia? Diagnose it.

Genito-Urinary Diseases

1. What is the most frequent cause of a continued gluty discharge after an attack of gonorrhœa?
2. What is balanitis? What causes it?
3. How many separate and distinct contagious diseases result from venereal contact? Name them.
4. What is tubercular syphilide?

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Genito-Urinary Diseases (cont.)

5. What is hypospadias?
6. What is the difference between a Hunterian chancre and a chancroid?

Physical Diagnosis

1. What is physical diagnosis?
2. What are the six methods used in physical diagnosis? Describe briefly their application.
3. What are the two classes of rales or rhonci? Name the varieties.
4. What does auricular diastole and ventricular systole mean?
5. How many sounds has the heart? How many murmurs?
6. What is the action of alkaline urine on red litmus paper?
7. What disease would be suggested to you if the urine had a specific gravity of 1007? What if it had a specific gravity of 1035?

Obstetrics

1. What is tubal pregnancy? What are the two immediate dangers of tubal pregnancy?
2. What membranes cover the fœtus? Name them and state their relation to the fœtus.
3. What foramen is found connecting the right and left auricle in the fœtal heart?
4. What veins carry arterial blood in the fœtus?
5. What symptoms would most strongly suggest placenta previa to you?
6. What is the average period, in days, of pregnancy? What were the two extremes that legitimized the child in the Code of Napoleon?
7. What is the position of the uterus during the first two months of pregnancy?

Anatomy

1. How many bones are there in the carpus? Name them in order from the radial to the ulnar side.
2. What valves guard the orifice of the pulmonary arteries? What guards the auriculo-ventricular opening on the left side of the heart? What surrounds the orifice of the aorta?
3. What is the average weight of the brain in the adult male?
4. Bound Scarpa's triangle.
5. How many bones in the tarsus? Name them.

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